

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT

TO: Yakima County Health District: DATE: _____

FROM: _____ FROM PHONE # _____

Yakima County health care providers and health care facilities should use this form to report Sexually Transmitted Disease (STD). Report STDs within three work days (see WAC 246-101-101/301). All information will be strictly managed confidentially. Your cooperation is both encouraged and appreciated.

PATIENT INFORMATION

LAST NAME			FIRST NAME			MIDDLE INITIAL:		
ADDRESS			TELEPHONE ()			REASON FOR EXAM (Check one) <input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam – No Symptoms <input type="checkbox"/> Exposed to Infection		
CITY/TOWN		STATE	ZIP CODE					
DATE OF DIAGNOSIS MO DAY YR		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female			DATE OF BIRTH MO DAY YR			
ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown			RACE – Check all that apply <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			GENDER OF SEX PARTNERS <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both <input type="checkbox"/> Unknown		

DIAGNOSIS – DISEASE

DIAGNOSIS - ✓ only one <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic-Uncomplicated <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Disseminated <input type="checkbox"/> Other Complications: _____ DATE TESTED: _____			GONORRHEA (lab confirmed) SITE(S) - ✓ all that apply <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input type="checkbox"/> Ocular <input type="checkbox"/> Other: _____			TREATMENT - ✓ all given/prescription(s) <input type="checkbox"/> Cefpodoxime <input type="checkbox"/> Doxycycline <input type="checkbox"/> Levofloxacin* <input type="checkbox"/> Cefixime Other, specify _____ *Quinolones not recommended as first choice for GC treatment; see treatment guidelines. DATE RX: _____			SYPHILIS <input type="checkbox"/> Primary (Chancere, etc.) <input type="checkbox"/> Secondary (Rash, etc.) <input type="checkbox"/> Early Latent (<1 yr) <input type="checkbox"/> Late Latent (>1 yr) <input type="checkbox"/> Congenital <input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Late RX GIVEN: _____ DATE RX: _____		
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--

DIAGNOSIS - ✓ only one <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic-Uncomplicated <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Other Complications: _____ DATE TESTED: _____			CHLAMYDIA TRACHOMATIS (lab confirmed) SITE(S) - ✓ all that apply <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input type="checkbox"/> Ocular <input type="checkbox"/> Other: _____			TREATMENT - ✓ all given/prescription(s) <input type="checkbox"/> Azithromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Erythromycin <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Other: _____ DATE RX: _____			HERPES SIMPLEX <input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal Laboratory Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No OTHER <input type="checkbox"/> Chancroid <input type="checkbox"/> Granuloma Inguinale <input type="checkbox"/> Lymphogranuloma Venereum		
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--

DIAGNOSING CLINICIAN			PERSON COMPLETING FORM		
FACILITY NAME			ADDRESS		
CITY		STATE	TELEPHONE ()		

PARTNER MANAGEMENT PLAN (✓ Select method of ensuring partner treatment)

- Yakima County Health District to assume responsibility for partner treatment. *Health District assistance only recommended if:*
 - Patient has had 2 or more sex partners in the last 60 days, or
 - Patient does not think he/she will have sex again with sex partners from the last 60 days, or
 - Patient is unable or unwilling to contact one or more partner, or
 - Patient is a man who has sex with other men.
- Provider will ensure all partners treated (**FREE medications available**). Indicate number to be treated (_____).
- All partners have been treated. Indicated number treated (_____).

INSTRUCTIONS
On Page 2

PRIVILEGED AND CONFIDENTIAL COMMUNICATIONS: The information contained in this message is privileged, confidential, or otherwise exempt from disclosure and is intended solely for the use of the individual(s) named above. If you are not the intended recipient, you are hereby advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this facsimile in error, please immediately notify the sender by telephone and destroy the original facsimile.

PARTNER MANAGEMENT PLAN INSTRUCTIONS

Gonorrhea or Chlamydial Infection: Partner Treatment

All partners should be treated as if they are infected.

If the provider takes responsibility to ensure partner treatment, the provider should examine and treat all patient's sex partners from the previous 60 days.

If this is **not** possible, patients should be offered medication to give to as many of their sex partners as they are able to contact and/or should be referred to Yakima County Health Department for partner notification assistance.

Free medication is available for your patient's partner(s).

To obtain **FREE medication** for your patient's partner(s), call or fax a prescription to one of the pharmacies participating in your area. Preprinted prescription are attached to this case report.

Note: Only participating pharmacies have stocks of FREE Public Health medication to dispense to patients for their partner(s).

Yakima County Health Department may also provide free medication to your patient to give to his or her partner(s).

The Yakima County Health Department recommends that you refer patients with any one or more of the following risks to the health department for help notifying their partners:

- Patient with 2 or more sex partners in the last 60 days , or
- Patient does not think he/she will have sex again with sex partners from the last 60 days, or
- Patient is unable/unwilling to contact one or more partner(s), or
- Patient is a man who has sex with other men

Although the Health Department requests that you refer patients with these risks to us, we also ask that you make every effort to help patients with these risks assure that their partners are treated, either by seeing the partners yourself or by offering patients free medication to give to their partners.

Complete the partner management plan on the Confidential Sexually Transmitted Disease Case Report FAX form to define a partner management plan.

For copies of this case report or questions on how to fill it out, call the Yakima Health Department: **509-249-6531**

Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV or granuloma inguinale are routinely contacted by Yakima County Health Department. Patients diagnosed with genital herpes should be advised to notify their sex partners and should be informed that their partners should contact their provider for testing.

RECOMMENDED REGIMENS FOR ANTIMICROBIALS LISTED ON CASE REPORTS*

Gonorrhea (uncomplicated):

Ceftriaxone	125-250 mg IM, single dose,	OR
Cefpodoxime	400 mg PO, single dose,	OR
Cefixime	400 mg PO, single dose,	OR

Alternatives:

Azithromycin.....2g PO as a single dose (additional chlamydia therapy not needed)
Health care providers should no longer use fluoroquinolones (Levofloxacin or Ciprofloxacin) as first line therapy due to increased prevalence of quinolone-resistant *Neisseria gonorrhoeae* (QRNG).

Plus, if Chlamydia infection is NOT ruled out

Azithromycin.....	1g PO as a single dose,	OR
Doxycycline	100 mg PO BID for 7 days	

Chlamydia Trachomatis (uncomplicated):

Azithromycin.....	1g PO single dose,	OR
Doxycycline	100 mg PO BID for 7 days,	OR
Erythromycin	(base 500 mg PO QID for 7 days,	OR
	(ethylsuccinate) 800 mg PO QID for 7 days, OR	
Levofloxacin	500 mg PO, for 7 days,	OR
Ofloxacin	300 mg PO, BID for 7 days	

Syphilis (primary, secondary or early latent < 1 year)

Benzathine penicillin G2.4 million units IM in a single dose

Syphilis (latent > 1 year, latent of unknown duration, tertiary [not neurosyphilis])

Benzathine penicillin G.....2.4 million units IM for 3 doses at 1 week intervals

*Refer to "STD Diagnostic and Treatment Guidelines" or CDC website: www.cdc.gov/std/treatment for further information on treating pregnant patients, infections of the pharynx, treatment of infants and other details.