

**CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD**

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| <b>PATIENT INFORMATION</b> | ⇒ Fill in ALL text fields and <u>mark</u> variables for complete demographic information as required by CDC. |
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|  |   |  |      |
|--|---|--|------|
| Name:  |   | DOB:   |      |
| Address:   |   | Phone: Home  | Cell |
| City:  | COUNTY of RESIDENCE:  | STATE, if not MT:  |      |
| Age:   |   | Zip:   |      |
| Sex: M <input type="checkbox"/> F <input type="checkbox"/> | Race: White <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> | Ethnicity: Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> |      |

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| <b>SPECIMEN COLLECTION/CLINICAL DIAGNOSIS</b> | ⇒ Fill in ALL text fields and <u>mark</u> variables for complete specimen collection information on patient. |
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|   |                                     |   |  |
|---|-------------------------------------|---|--|
| Name of Lab Performing Test:                          |                                     | Other: <input type="checkbox"/>                               |  |
| Date Lab Specimen Collected:                          | Test Type:                          | Test Source:  |  |
| Date Lab Report Received:                             | Date Reported to Health Department: |   |  |
| Patient Diagnosis: Chlamydia <input type="checkbox"/> | Syphilis ⇒                          | PID: Yes <input type="checkbox"/> No <input type="checkbox"/> | Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Gonorrhea <input type="checkbox"/>                    |                                     |   |  |
| Health Care Provider:                                 |                                     |   | Phone:   |
| Provider's Address:                                   |                                     |   |  |

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|--------------------------------------|---|
| <b>PATIENT TREATMENT INFORMATION</b> | ⇒ Fill in date & mark or fill in text for treatment information at minimum. |
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|       |  |                                     |  |
|-------|--|-------------------------------------|--|
| Date: | Med: Azithromycin <input type="checkbox"/> | Dose: 1 gm <input type="checkbox"/> | Duration: X 1 <input type="checkbox"/> |
| Date: | Med:                                       | Dose:                               | Duration:                              |

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| <b>CONTACT INTERVIEW</b> | ⇒ Complete text fields and date this section. |
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|              |       |                      |
|--------------|-------|----------------------|
| Interviewer: | Date: | Interviewing Agency: |
|--------------|-------|----------------------|

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| <b>CONTACT INFORMATION</b><br><i>If necessary, please include additional sheets w/patient and contact's name(s).</i> | ⇒ Please # each additional contact and collect <b>COMPLETE</b> locating information. Fill in text fields and required Disposition Code for each disease. |
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| Local Contact Name (Use supplemental/OOJ form as needed) | Sex  | Date of Last Exposure | Test Date | Date of Treatment or Previous Tx | *Disposition Code Required CT/GC/Syphilis |
|--|--|-----------------------|-----------|----------------------------------|---|
| 1.   | M <input type="checkbox"/><br>F <input type="checkbox"/> |                       |           |                                  |   |
| 2.   | M <input type="checkbox"/><br>F <input type="checkbox"/> |                       |           |                                  |   |

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| <b>PATIENT RISK ASSESSMENT INFORMATION</b> | ⇒ Mark applicable answers and complete patient exposure information within past 12 months as required by CDC. |
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|                                 |  |   |   |
|---------------------------------|--|---|---|
| Had sex w/male?                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Injection drug use?   | Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| Had sex w/female?               | Yes <input type="checkbox"/> No <input type="checkbox"/> | Shared injection equipment?   | Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| Had sex w/transgender?          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Injection/Non-Inject drug usage? (Note drugs: )                     | Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| Had sex w/anon. partner?        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Was patient tested for HIV?   | Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> Not Asked <input type="checkbox"/> |
| Had sex w/o condom?             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Patient's HIV status?   | Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown <input type="checkbox"/>  |
| Had sex while intoxicated/high? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Prior STD history?  | Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| Exchanged drugs/money for sex?  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Was patient counseled for HIV?                                      | Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| Females-had sex w/known MSM?    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Met partners via internet?  | Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| Had sex w/known IDU?            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Was patient screened for?   | Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/>  |
| Been incarcerated?              | Yes <input type="checkbox"/> No <input type="checkbox"/> | Partners referred to agencies offering free/reduced-cost testing?   | Yes <input type="checkbox"/> No <input type="checkbox"/>  |
|                                 |  | Partners referred to agencies offering free/reduced-cost treatment? | Yes <input type="checkbox"/> No <input type="checkbox"/>  |
|                                 |  | Reason for exam?  | Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Contact to STD <input type="checkbox"/> Prenatal <input type="checkbox"/>          |

\*Disposition Codes

- |                                   |  |  |
|-----------------------------------|--|--|
| A. Preventive Treatment           | D. Infected, not Treated                 | G. Insufficient Information to Begin Investigation |
| B. Refused Preventive Treatment   | E. Previously Treated for this Infection | H. Unable to Locate                                |
| C. Infected, Brought to Treatment | F. Not Infected                          | J. Located, Refused Examination                    |
|                                   |  | K. Out of Jurisdiction                             |

Comment Section:

|   |   |
|---|---|
| Local Health Department Reviewer:   | If out of jurisdiction:                         |
| New Case <input type="checkbox"/>   | Case Referred to DPHHS <input type="checkbox"/> |
| Update of prior report <input type="checkbox"/> Final/Completed report <input type="checkbox"/> | County:   |