

## CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE (STD) CASE REPORT

*Report STDs within three working days. (WAC 246-101-101/301)*

PATIENT INFORMATION						
LAST NAME		FIRST NAME		MIDDLE NAME	DATE OF BIRTH MO   DAY   YR	
ADDRESS			CITY	STATE	ZIP CODE	
TELEPHONE		EMAIL		ENGLISH SPEAKING? <input type="checkbox"/> Yes <input type="checkbox"/> No Language _____	DIAGNOSIS DATE MO   DAY   YR	
SEX ASSIGNED AT BIRTH <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Refused		GENDER IDENTITY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans MTF <input type="checkbox"/> Trans FTM <input type="checkbox"/> Nonbinary/Genderqueer <input type="checkbox"/> Other _____		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"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian/Alaskan Native	
CURRENTLY PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	REASON FOR EXAM (check one) <input type="checkbox"/> Exposed to Infection <input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam (no symptoms)	GENDER OF SEX PARTNERS (check all that apply) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans MTF <input type="checkbox"/> Trans FTM <input type="checkbox"/> Nonbinary/Genderqueer <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		HIV STATUS <input type="checkbox"/> Previous positive <input type="checkbox"/> New HIV diagnosis this visit* <input type="checkbox"/> Negative HIV test this visit <input type="checkbox"/> Did not test (unknown status) <small>*Complete &amp; submit HIV/AIDS Case Report</small>	CURRENTLY ON PREP? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
DIAGNOSIS—DISEASE						
GONORRHEA (Lab Confirmed)			SYPHILIS			
DIAGNOSIS (check 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 _____		SITES (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"/> Vagina <input type="checkbox"/> Ocular <input type="checkbox"/> Other _____		TREATMENT (check all prescribed) <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 1 g <input type="checkbox"/> Cefixime <input type="checkbox"/> 400 mg <input type="checkbox"/> 800 mg <input type="checkbox"/> Azithromycin <input type="checkbox"/> 1 g <input type="checkbox"/> 2 g <input type="checkbox"/> Doxycycline <input type="checkbox"/> 100 mg BID x 7 days <input type="checkbox"/> Gentamicin <input type="checkbox"/> 240 mg <input type="checkbox"/> Gemifloxacin <input type="checkbox"/> 320 mg <input type="checkbox"/> Other _____		STAGE (check one) <input type="checkbox"/> Primary (chancre, etc.) <input type="checkbox"/> Secondary (rash, etc.) <input type="checkbox"/> Early latent (< 1 year) <input type="checkbox"/> Unknown Duration or Late <input type="checkbox"/> Congenital
Date Tested _____		Date Prescribed: _____		MANIFESTATIONS (check all that apply) <input type="checkbox"/> Neurologic <input type="checkbox"/> Otic <input type="checkbox"/> Ocular <input type="checkbox"/> Tertiary		
CHLAMYDIA TRACHOMATIS (Lab Confirmed)						
DIAGNOSIS (check 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: _____		SITES (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"/> Vagina <input type="checkbox"/> Ocular <input type="checkbox"/> Other _____		TREATMENT (check all prescribed) <input type="checkbox"/> Azithromycin <input type="checkbox"/> 1 g <input type="checkbox"/> Doxycycline <input type="checkbox"/> 100 mg BID x 7 days <input type="checkbox"/> Levofloxacin <input type="checkbox"/> 500 mg daily x 7 days <input type="checkbox"/> Other _____		
Date Tested _____		Date Prescribed _____		TREATMENT (check one) Bicillin L-A <input type="checkbox"/> 2.4 MU IM x 1 <input type="checkbox"/> 2.4 MU IM x 3 Doxycycline <input type="checkbox"/> 100 mg BID x 14 days <input type="checkbox"/> 100 mg BID x 28 days Benzathine <input type="checkbox"/> 50,000 units/kg IM x 1 PCN-G <input type="checkbox"/> 50,000 units/kg IM x 3 Aqueous Crystalline Penicillin G <input type="checkbox"/> 18-24 MU/day IV for 10-14 days <input type="checkbox"/> Other _____		
Date Prescribed _____		Date Prescribed _____		Date Prescribed _____		
HERPES SIMPLEX			OTHER DISEASES			
DIAGNOSIS <input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal		LABORATORY CONFIRMATION <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Chancroid <input type="checkbox"/> Granuloma Inguinale <input type="checkbox"/> Lymphogranuloma Venereum		
PARTNER MANAGEMENT PLAN (Check one or more options)						
Providers should manage partner treatment by either treating partners in-person or by prescribing medication for patients to give to their sex partners (see side 2 for additional information).						
<input type="checkbox"/> In-person evaluation – Number of partners treated following medical evaluation: _____						
<input type="checkbox"/> Patient-delivered treatment* - Number of partners for whom provider prescribed or provided expedited partner therapy (EPT) medication pack to be delivered by the patient to their partner(s): _____ *Patient-delivered treatment is not recommended for men who have sex with men or patients with syphilis.						
Turn over for information on partner management						
REPORTING CLINIC INFORMATION						
DATE		FACILITY NAME		DIAGNOSING CLINICIAN		
ADDRESS			CITY	STATE	ZIP CODE	
PERSON COMPLETING FORM			TELEPHONE	EMAIL		

**Thank you for reporting a STD. All information will be managed with the strictest confidentiality.**

PRIVILEGED AND CONFIDENTIAL COMMUNICATION: 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 Chlamydia Infection: Partner Treatment

All partners should be treated as if they are infected.

The Washington State Department of Health strongly encourages providers to take responsibility to ensure partner treatment for heterosexuals, by examining and treating all patient's sex partners from the previous 60 days.

If an examination is not possible, providers should offer medication for all sex partners whom patients are able to contact.

Spokane Regional Health District may be able to provide free medication to your patient to give to his or her partner(s), if resources permit. Please contact your local health jurisdiction to report cases and inquire about partner management resources, possibly including EPT medications.

Spokane Regional Health District recommends you refer all **MSM patients** and **all patients with syphilis or newly diagnosed HIV** to the health department for help notifying partners to ensure that partners receive medication, the opportunity to test for HIV, syphilis, gonorrhea, and chlamydia, and evaluation for HIV Pre-Exposure Prophylaxis (PrEP). Please inform the patient that the health department will contact them to assist with partner notification.

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 assure that their partners are treated.

**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 **Spokane Regional Health District (509) 324.1494**.

### Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV, or granuloma inguinale are routinely contacted by Spokane Regional Health District. 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 REPORTS\*

### GONORRHEA -- Uncomplicated

Ceftriaxone 250 mg IM as a single dose **PLUS** Azithromycin 1g PO as a single dose

**Alternatives:**

Cefixime 400 mg PO as a single dose **PLUS** Azithromycin 1g PO as a single dose **OR**

**For beta-lactam allergic patients:**

Azithromycin 2g PO as a single dose **PLUS** Gentamicin 240mg IM as a single dose **OR** Gemifloxacin 320mg PO as a single dose

### CHLAMYDIA -- Uncomplicated

Azithromycin 1g PO as a single dose **OR**

Doxycycline 100 mg PO BID for 7 days

**Alternatives:**

Erythromycin (base) 500 mg PO QID for 7 days **OR**

Ethylsuccinate 800 mg PO QID for 7 days **OR**

Ofloxacin 300 mg PO BID for 7 days **OR**

Levofloxacin 500 mg PO for 7 days

### SYPHILIS -- PRIMARY, SECONDARY, OR EARLY LATENT (<1 YEAR)

Benzathine penicillin G 2.4 million units IM in a single dose

### SYPHILIS -- LATE OR UNKNOWN DURATION

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

\* Refer to "STD Diagnostic and Treatment Guidelines" or the Centers for Disease Control and Prevention's (CDC's) website (<http://www.cdc.gov/std/tg2015/default.htm>) for further information on treating pregnant patients, infections of the pharynx, treatment of infants and other details.

DOH 347-102, updated 03.23.20. For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).