

# SEXUALLY TRANSMITTED DISEASE CONFIDENTIAL CASE REPORT

**CRITERIA FOR REPORTING – Reported by county of residence as specified in OAR 333-19**, each case of Chlamydia -- Chancroid -- Gonorrhea -- Lymphogranuloma Venereum -- Early Syphilis **shall be reported to the local health department within one day from time of identification.** Acute Pelvic Inflammatory Disease (PID) is reported within one week.

## USE OF THE CONFIDENTIAL STD CASE REPORT

The **STD Case Report** is designed for health care providers to report sexually transmitted diseases that are designated by the Oregon Health Division as legally reportable (see OAR 333-19). These diseases are of such major public health concern that surveillance of their occurrence is in the public interest. **All information will be managed in the strictest confidence.** Your cooperation is both encouraged and appreciated. Please call if you have any questions about the information required to complete the form.

### REPORTING INSTRUCTIONS

Confidential case reports must be reported to the local health department of patient's residency by fax, telephone or mail. The report should include all the information below.

**For Marion County residents:**

Marion County Confidential Fax: (503) 588-5353

Phone: Marion County Clinic (503) 588-5342

## CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT

Last Name, First, MI				Pregnant: <input type="checkbox"/> Yes _____ weeks, <input type="checkbox"/> No <input type="checkbox"/> Unk			
Address				Phone Number			
City/Town		State		Zip Code		County	
Date of Diagnosis	Race	Ethnicity		Sex	Marital Status		Age
	<input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> AP <input type="checkbox"/> AI <input type="checkbox"/> O	<input type="checkbox"/> H <input type="checkbox"/> NH	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D			

RACE: **W**-White; **B**-Black; **A**-Asian/**PI**-Pacific Islander; **AI**-American Indian/**AN**-Alaskan Native; **O**-Other/**U**-Unknown

<p style="text-align: center;"><b>GONORRHEA (lab confirmed)</b></p> <p><b>Diagnosis - ✓ only one</b></p> <p><input type="checkbox"/> Asymptomatic  <input type="checkbox"/> Symptomatic – Uncomplicated  <input type="checkbox"/> Pelvic Inflammatory Dis. (PID)  <input type="checkbox"/> Ophthalmia  <input type="checkbox"/> Disseminated  <input type="checkbox"/> Other Complications:</p> <p>DATE TESTED _____ TEST TYPE _____</p>	<p style="text-align: center;"><b>TREATMENT/DOSE CHECK ALL</b></p> <p>Date of Treatment _____</p> <p style="text-align: center;">DOSE</p> <p><input type="checkbox"/> Ceftriaxone _____  <input type="checkbox"/> Cefixime _____  <input type="checkbox"/> Spectinomycin _____  <input type="checkbox"/> Ciprofloxacin _____                  # of Days _____</p> <p><input type="checkbox"/> Benzathine Pen G                  Dose _____ # of Doses _____                  Date _____                  Date _____                  Date _____</p> <p style="text-align: center;">DOSE</p> <p><input type="checkbox"/> Tetracycline/Doxy _____  <input type="checkbox"/> Azithromycin _____  <input type="checkbox"/> Erythromycin _____  <input type="checkbox"/> Metronidazole _____                  # of Days _____</p> <p><input type="checkbox"/> Other _____                  DOSE _____                  # of Days _____</p>	<p style="text-align: center;"><b>OTHER SEXUALLY TRANSMITTED DISEASES</b></p> <p><input type="checkbox"/> Chancroid  <input type="checkbox"/> Lymphogranuloma Venereum</p> <p style="text-align: center;"><b>SYPHILIS</b></p> <p><input type="checkbox"/> EI/CI/CA POS  <input type="checkbox"/> RPR _____  <input type="checkbox"/> VDRL _____  <input type="checkbox"/> TP-PA _____  <input type="checkbox"/> FTA-ABS _____  <input type="checkbox"/> OTHER _____                  DATE _____</p> <p style="text-align: center;"><b>REASON FOR EXAM (CHECK ONE)</b></p> <p><input type="checkbox"/> Symptomatic <input type="checkbox"/> Pregnant  <input type="checkbox"/> Routine Exam – No Symptoms-  <input type="checkbox"/> Exposed to infection</p> <p style="text-align: center;"><b>REPORTABLE SYNDROME</b>                  (No laboratory confirmation of gonorrhea or Chlamydia)  <input type="checkbox"/> ACUTE PELVIC INFLAMMATORY DISEASE (PID) Date Diagnosed _____  <b>Note date of treatment and treatment in middle column.</b></p>
<p style="text-align: center;">Lab information (If available)</p> <p>Lab Used: _____                  Collection Date: _____                  Reported Date: _____</p>	<p>Provider _____</p> <p>Address _____</p> <p>City and State _____ Phone: _____</p>	

Was patient told that partner needed to be treated? \_\_\_\_\_

Was partner treated, given an Rx or Expedited Partner Therapy by you? \_\_\_\_\_

If yes, what is partner's name \_\_\_\_\_ Date of TX \_\_\_\_\_ Medication \_\_\_\_\_

**If client or partner cannot afford treatment, please refer them to Marion County Health Department (503) 588-5342**