

CONFIDENTIAL SEXUALLY TRANSMITTED INFECTION (STI) CASE REPORT
Report STIs within 3 work days (WAC 246-101-101/301)

PATIENT INFORMATION						
LAST NAME		FIRST NAME		MIDDLE NAME	DATE OF BIRTH MO DAY YR	
ADDRESS (<input type="checkbox"/> Unhoused or unstably housed in the past 3 months)			CITY	STATE	ZIP CODE	
TELEPHONE ()		EMAIL		ENGLISH SPEAKING? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*instructions on pg. 3</small> Preferred Language (Code*: L _ _)	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"/> Transgender MTF <input type="checkbox"/> Female <input type="checkbox"/> Transgender FTM <input type="checkbox"/> Nonbinary / Genderqueer <input type="checkbox"/> Other _____ <input type="checkbox"/> Refused		ETHNICITY <input type="checkbox"/> Hispanic or Latina/o/x <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Refused	RACE CATEGORY (check all that apply)*: <small>*Instructions on page 3</small> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Refused		
			EXTENDED RACE CODE(S)*: <input type="checkbox"/> R <input type="checkbox"/> R <input type="checkbox"/> R <input type="checkbox"/> R <input type="checkbox"/> R			
CURRENTLY PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> NA	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"/> Transgender MTF <input type="checkbox"/> Female <input type="checkbox"/> Transgender FTM <input type="checkbox"/> Nonbinary / Genderqueer <input type="checkbox"/> Unknown		HIV STATUS <small>*Submit HIV/AIDS Case Report</small> <input type="checkbox"/> Previous positive <input type="checkbox"/> New HIV diagnosis at this visit* <input type="checkbox"/> Negative HIV test at this visit <input type="checkbox"/> Did not test (unknown status)	CURRENTLY ON PREP? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
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: _____ Date Tested: _____		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: _____ Date Prescribed: _____		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 MANIFESTATIONS (check all that apply): <input type="checkbox"/> Neurologic <input type="checkbox"/> Otic <input type="checkbox"/> Ocular <input type="checkbox"/> Tertiary
CHLAMYDIA (lab confirmed)			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 <input type="checkbox"/> 18-24 MU/day IV Crystalline for 10-14 days Penicillin G: Other: _____ Date Prescribed: _____			
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: _____ Date Tested: _____		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 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 TREATMENT 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: _____			Turn over for Partner Treatment Plan Instructions			
<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						
REPORTING CLINIC INFORMATION						
DATE		FACILITY NAME		DIAGNOSING CLINICIAN		
ADDRESS			CITY	STATE	ZIP	
PERSON COMPLETING FORM			TELEPHONE ()	EMAIL		

Thank you for reporting an STI. All information will be managed with the strictest confidentiality.

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.

RECOMMENDED REGIMENS FOR ANTIMICROBIALS LISTED ON REPORTS*

GONORRHEA -- Uncomplicated

Ceftriaxone 500 mg IM as a single dose for persons weighing < 150 kg (300 lbs), or 1 g IM as a single dose for persons weighing > 150 kg (300 lbs)[†]

Alternatives for uncomplicated infections of the cervix, urethra, or rectum:[‡]

Gentamicin 240 mg IM as a single dose PLUS azithromycin 2 g PO as a single dose **OR**

Cefixime 800 mg orally as a single dose[†]

[†] *If treating with ceftriaxone or cefixime, and chlamydia infection has not been excluded, providers should treat for chlamydia with doxycycline 100 mg PO BID for 7 days. During pregnancy, azithromycin 1 g PO as a single dose is recommended to treat chlamydia.*

[‡] *Ceftriaxone is the only recommended treatment for pharyngeal gonorrhea. Consult an infectious disease provider or other STD expert for assistance if alternative treatment is required.*

CHLAMYDIA -- Uncomplicated

Doxycycline 100 mg PO BID for 7 days **OR**

Azithromycin 1g PO as a single dose

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 (<https://www.cdc.gov/std/treatment/default.htm>) for further information on treating pregnant patients, infections of the pharynx, patients with allergies, treatment of infants, and other details.

List of Preferred Languages:

Instructions: Complete the *Preferred Language* section if the patient's preferred language is **not** English. Patient's preferred language shall be identified by the patient and reported using one of the below categories.

Language Identity Codes:

(L01) Amharic	(L18) Karen	(L35) Sign languages
(L02) Arabic	(L19) Khmer/Cambodian	(L36) Somali
(L03) Balochi/Baluchi	(L20) Kinyarwanda	(L37) Spanish/Castilian
(L04) Burmese	(L21) Korean	(L38) Swahili/Kiswahili
(L05) Cantonese	(L22) Kosraean	(L39) Tagalog
(L06) Chinese (unspecified)	(L23) Lao	(L40) Tamil
(L07) Chamorro	(L24) Mandarin	(L41) Telugu
(L08) Chuukese	(L25) Marshallese	(L42) Thai
(L09) Dari	(L26) Mixteco	(L43) Tigrinya
(L10) Farsi/Persian	(L27) Nepali	(L44) Ukrainian
(L11) Fijian	(L28) Oromo	(L45) Urdu
(L12) Filipino/Pilipino	(L29) Panjabi/Punjabi	(L46) Vietnamese
(L13) French	(L30) Pashto	(L77) Other language
(L14) German	(L31) Portuguese	(L88) Patient declined to respond
(L15) Hindi	(L32) Romanian/Rumanian	(L99) Unknown
(L16) Hmong	(L33) Russian	
(L17) Japanese	(L34) Samoan	

Race Category and Identity Instructions:

Instructions: The patient's race may either be reported in the general *Race Category* section or the *Extended Race* section on page 1 of the case report. When completing the *Extended Race* section, please report using the codes provided in the list below. If the patient self-identifies as more than one race, each race code shall be reported within the *extended race* section. **Unknown** race can be documented within either one of the race sections.

Extended Race Codes:

(R01) Afghan	(R22) Fijian	(R43) Mexican/Mexican American	(R64) Tongan
(R02) Afro-Caribbean	(R23) Filipino	(R44) Middle Eastern	(R65) Ugandan
(R03) Alaska Native	(R24) First Nations	(R45) Mien	(R66) Ukrainian
(R04) American Indian	(R25) Guamanian or Chamorro	(R46) Moroccan	(R67) Vietnamese
(R05) Arab	(R26) Hmong/Mong	(R47) Native Hawaiian	(R68) White
(R06) Asian	(R27) Indigenous-Latina/o/x	(R48) Nepalese	(R69) Yemeni
(R07) Asian Indian	(R28) Indonesian	(R49) North African	(R77) Other race
(R08) Bamar/Burman/Burmese	(R29) Iranian	(R50) Oromo	(R99) Unknown
(R09) Bangladeshi	(R30) Iraqi	(R51) Pacific Islander	
(R10) Bhutanese	(R31) Japanese	(R52) Pakistani	
(R11) Black or African American	(R32) Jordanian	(R53) Puerto Rican	
(R12) Central American	(R33) Karen	(R54) Romanian/Rumanian	
(R13) Cham	(R34) Kenyan	(R55) Russian	
(R14) Chicana/o or Chicanx	(R35) Khmer/Cambodian	(R56) Samoan	
(R15) Chinese	(R36) Korean	(R57) Saudi Arabian	
(R16) Congolese	(R37) Kuwaiti	(R58) Somali	
(R17) Cuban	(R38) Lao	(R59) South African	
(R18) Dominican	(R39) Lebanese	(R60) South American	
(R19) Egyptian	(R40) Malaysian	(R61) Syrian	
(R20) Eritrean	(R41) Marshallese	(R62) Taiwanese	
(R21) Ethiopian	(R42) Mestizo	(R63) Thai	