

**CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT**

**Report STDs within three work 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 (Lang. _____)	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: _____		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"/> Black <input type="checkbox"/> Other <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian / Other Pacific Islander
CURRENTLY PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <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"/> Other <input type="checkbox"/> Unknown		HIV STATUS *Submit HIV/AIDS Case Report <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: _____	
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 STD. 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.

## 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.

Adams County Public Health 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.

Adams County Public Health 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 **Adams County Public Health: Ritzville: (509) 659-3315/ Othello: (509) 488-2031**.

### Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV, or granuloma inguinale are routinely contacted by public health staff. 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. Per CDC treatment guidelines, sex partners of patients who are diagnosed with early syphilis (primary, secondary, or early latent) and may be incubating disease should be treated regardless of test results. Alternative treatment for penicillin allergy among non-pregnant patients, such as an appropriate dosage of doxycycline, can also be found in the guidelines.

## 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)<sup>†</sup>

**Alternatives for uncomplicated infections of the cervix, urethra, or rectum:<sup>‡</sup>**

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<sup>†</sup>

<sup>†</sup> 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.

<sup>‡</sup> 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.

DOH 347-102, updated 4/23/2021. 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).