

## **STD Case Report**

Confidential Fax Line: (215) 238-6946

PATIENT INFORMATION					
LAST NAME FII		IRST NAME	MIDDLE	E INITIAL	DATE OF BIRTH
ADDRESS	,	СІТУ	rz	TATE	ZIP CODE
TELEPHONE		SEX AT BIRTH	CURRENT GENDER	DER IF FEMALE, PREGNANT	
		□Male □Female	□Male □Femal	le □Y	res □No □Unknown
ETHNICITY	RACE (Check all that apply)	GENDER OF SEX PARTNER(S)	REASON FOR EXAM (Cone)	Check DAT	TE OF LAST HIV TEST:
□Hispanic	□White □Black □Asian	□Male	Symptomatic		
□Non-Hispanic	☐American Indian/Alaskan Native	□Female			<b>ULT</b> :□Pos □Neg □Unk
□ Unknown □ Native Hawaiian/Other Pacific Islan		der Both	☐Routine exam – n symptoms		ATIENT ON PrEP?
	□Other □Unknown	□Unknown	☐Exposed to infect	ion 🗆 Y	∕es □No □Unknown
DIAGNOSIS – Include lab results when sending case report forms					
GONORRHEA		<u>.</u>			
Sites (all that apply)		DATE TREATED:	DATE TREATED:(check all that apply)		
□Cervix □Ur	rethra □Urine □Rectum	☐ Ceftriaxone 250mg IM ☐ Azithromycin 1g ☐ Cefixime 400 mg PO ☐ Azithromycin 2g			
□Pharynx □Va	agina 🗆 Other:	□ Doxycycline 100mg BIDx7 □ Gentamicin 240mg IM □ Gemifloxacin 320mg PO			
		□Other:			
		WAS THE PATIENT GIVEN MEDICATION/PRESCRIPTION FOR THEIR PARTNER(S)? ☐ Yes ☐ No ☐ Unk			
CHLAMYDIA					
Sites (all that apply)		DATE TREATED:(check all that apply)			
□Cervix □Ur	ethra 🗆 Urine 🗆 Rectum	☐ Azithromycin 1g ☐ Azithromycin 2g ☐ Doxycycline 100mg BIDx7			
□Pharynx □Vagina □Other:		Other:			
,		WAS THE PATIENT GIVEN MEDICATION/PRESCRIPTION FOR THEIR PARTNER(S)?☐Yes ☐No ☐Unk			
SYPHILIS					
☐Primary (chan	cre) $\square$ Secondary (rash, etc.)	DATE TREATED:(check all that apply)			
☐Early latent (<1 year duration but no symptoms)		☐Bicillin 2.4mu IMx1 ☐Bicillin 2.4mu IMx3wks ☐Other:			
□Late latent (>1	year duration but no symptoms)	DATE OF LAST RPR:	LAST RPR: RESULT:☐Pos ☐Neg ☐Unk		
□Unknown dura	ation   Congenital	DESCRIBE SYMPTOMS, IF NOTED:			
Neurosyphilis:	lYes □No				
OTHER*					
☐ Chancroid ☐ Lymphogranuloma Venereum *Call 215-685-6737 to discuss further					
DEDCON COMPLETE		EPORTING CLINIC INFORM	MATION	DATE	
PERSON COMPLETI	IND FURIVI			DATE	
FACILITY NAME				TELEPHONE	E
ADDRESS				ZIP CODE	
	Thank you for reporting a	STD. All information will be manage	d with the strictest confiden	tiality	

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