

**CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT**  
*Report STDs within three work days (WAC 246-101-101/301)*

PATIENT INFORMATION					
LAST NAME		FIRST NAME		MIDDLE INITIAL	
ADDRESS		CITY		STATE	ZIP CODE
DATE OF BIRTH		TELEPHONE		EMAIL	
MO	DAY	YR	( ) ( ) ( )		
SEX		ETHNICITY		RACE (Check all that apply)	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgendered Male to Female <input type="checkbox"/> Transgendered Female to Male		<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
GENDER OF SEX PARTNERS		If Female, PREGNANT?		REASON FOR EXAM (Check one)	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam – No Symptoms <input type="checkbox"/> Exposed to Infection	
DATE OF DIAGNOSIS		HIV TESTED AT THIS VISIT?*		*If newly HIV positive, complete and submit the HIV/AIDS Case Report	
MO	DAY	YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previous Positive		
DIAGNOSIS – DISEASE					
GONORRHEA (lab confirmed)			SYPHILIS		
<b>DIAGNOSIS - √ only one</b> <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: _____			<b>SITE(S) - √ all that apply</b> <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: _____		<b>TREATMENT - √ all prescribed</b> <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Cefixime <input type="checkbox"/> Other: _____  DATE RX: _____
			<input type="checkbox"/> Primary (Chancere, etc.) <input type="checkbox"/> Secondary (Rash, etc.) <input type="checkbox"/> Early Latent (<1 yr) <input type="checkbox"/> Late Latent (>1 yr) <input type="checkbox"/> Late (with symptoms) <input type="checkbox"/> Congenital <input type="checkbox"/> Also Neurosyphilis  RX GIVEN: _____ DATE RX: _____		
CHLAMYDIA TRACHOMATIS (lab confirmed)			HERPES SIMPLEX		
<b>DIAGNOSIS - √ only one</b> <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: _____			<b>SITE(S) - √ all that apply</b> <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: _____		<b>TREATMENT - √ all prescribed</b> <input type="checkbox"/> Azithromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Other: _____  DATE RX: _____
			<input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal Laboratory Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>OTHER</b> <input type="checkbox"/> Chancroid <input type="checkbox"/> Granuloma Inguinale <input type="checkbox"/> Lymphogranuloma Venereum		
PARTNER MANAGEMENT PLAN √ Select method of ensuring partner treatment					
1. <input type="checkbox"/> Provider will ensure <u>all</u> partners are treated (FREE medications available). Indicate number to be treated (____). 2. <input type="checkbox"/> All partners have been treated. Indicate number treated (____). 3. <input type="checkbox"/> Health Department to assume responsibility for partner treatment (if resources permit).					
<b>Partner Plan Instructions Over</b>					
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 Chlamydial Infection: Partner Treatment

All partners should be treated as if they are infected.

If the provider takes responsibility to ensure partner treatment, the provider should examine and treat all patient's sex partners from the previous 60 days.

If this is not possible, patients should be offered medication to give to as many of their sex partners as they are able to contact and/or should be referred to Jefferson County Public Health for partner notification assistance.

Free medication is available for your patient's partner(s).

To obtain FREE medication for your patient's partner(s), call or fax a prescription to one of the pharmacies participating in your area.

For a prescription FAX form and list of participating pharmacies, call Jefferson County Public Health: 360-385-9446.

Note: Only participating pharmacies have stocks of FREE Public Health medication to dispense to patients for their partner(s).

Jefferson County Public Health may also provide free medication to your patient to give to his or her partner(s).

The Jefferson County Public Health recommends that you refer patients with any one or more of the following risks to the health department for help notifying their partners:

- Patient with 2 or more sex partners in the last 60 days , or
- Patient does not think he/she will have sex again with sex partners from the last 60 days, or
- Patient is unable/unwilling to contact one or more partner(s), or
- Patient is a man who has sex with other men

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 with these risks assure that their partners are treated, either by seeing the partners yourself or by offering patients free medication to give to their partners.

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 Jefferson County Public Health: 360-385-9446.

### Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV or granuloma inguinale are routinely contacted by Jefferson County Public Health. 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 CASE REPORTS\*

#### Gonorrhea (uncomplicated):

Ceftriaxone.....250 mg IM as a single dose,

PLUS Azithromycin 1g PO as a single dose,  
OR Doxycycline 100 mg PO BID for 7 days

#### Alternatives:

Cefixime .....400 mg PO as a single dose,

PLUS Azithromycin 1g PO as a single dose,  
OR Doxycycline 100 mg PO BID for 7 days

#### OR

Azithromycin.....2g PO as a single dose

Fluoroquinolones (Levofloxacin or Ciprofloxacin, etc.) are no longer recommended for the treatment of gonorrhea due to increased prevalence of quinolone-resistant *Neisseria gonorrhoeae* (QRNG).

#### Chlamydia trachomatis (uncomplicated):

Azithromycin..... 1g PO as a single dose,

OR

Doxycycline ..... 100 mg PO BID for 7 days,

OR

#### 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

Levofloxacin ..... 500 mg PO for 7 days,

OR

#### Syphilis (primary, secondary or early latent < 1 year)

Benzathine penicillin G ..... 2.4 million units IM in a single dose

#### Syphilis (latent > 1 year, latent of unknown duration, tertiary [not neurosyphilis])

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

\*Refer to "STD Diagnostic and Treatment Guidelines" or CDC website: [www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment) for further information on treating pregnant patients, infections of the pharynx, treatment of infants and other details.



**Washington State STD Expedited Partner Therapy Project  
Fax Prescription for STD Treatment Packs**

**TO:**

<b>Pharmacy:</b> <u>Check (J) Pharmacy in Table Below</u>	<b>Date:</b> _____
<b>Rx: Patient Name:</b> _____ (intended recipient)	<b>DOB:</b> _____
<b>Person Picking up Meds:</b> _____	<b>DOB:</b> _____
<b>Rx: Dispense medications as checked below at no charge to patient. Medications to be dispensed without childproof safety cap.</b>	
<input type="checkbox"/> <b>Public Health Pack 1:</b> Azithromycin, 1 gram (Zithromax) PO once stat	<input type="checkbox"/> <b>No Known adverse drug reactions</b>
<input type="checkbox"/> <b>Public Health Pack 2:</b> Cefixime 400 mg (Suprax) once PO stat and Azithromycin, 1 gram (Zithromax) PO once stat	<input type="checkbox"/> <b>Unknown adverse drug reactions</b>
_____ <b>Provider Signature</b> (Dispense as Written)	_____ <b>Provider Signature</b> (Substitutions Permitted)

Indicate (J) Pharmacy To Dispense Medications – Participating Pharmacies in Jefferson County				
J	Pharmacy Name	Fax #	Address	Phone
	Jefferson County Health Dept.	<b>360-385-3878</b>	615 Sheridan St Port Townsend	360-385-9400
	Safeway #538	<b>360-385-0573</b>	442 Sims Way Port Townsend	360-385-2860

**FROM:**

Prescribing Provider Contact Information	
<b>Name:</b> _____	<b>Fax:</b> _____
<b>Address:</b> _____	<b>Phone:</b> _____