

REPORT ONLY LAB CONFIRMED CASES

3021555876

INSTRUCTIONS: Print CAPITAL LETTERS clearly within the boxes with a black or blue pen. Do not touch the sides of the boxes. For circles, either completely fill them in or mark with an "X" or "✓". Do not use labels on this form. Do not submit photocopies of this form.

2009

PATIENT'S LAST NAME

SAMPLE ONLY - DO NOT COPY

COUNTRY OF BIRTH

- United States
- Other (specify) _____
- Unknown

FIRST NAME

M.I.

- HOMELESS
- ADDRESS UNKNOWN

ADDRESS

APT/UNIT NO.

CITY/TOWN

STATE

ZIP CODE

DATE OF BIRTH (MM DD YYYY)

____/____/____

MEDICAL RECORD NO.

AREA CODE

____-

PHONE NUMBER

____-____

GENDER (Mark one only)

- Male
- Female Pregnant? Yes ___ wks
- Transgender (M to F) No
- Transgender (F to M) Unknown

ETHNICITY (Mark one only)

- Hispanic or Latino
- Non-Hispanic or Non-Latino
- Unknown

RACE (Mark all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other (specify): _____
- Unknown

GENDER OF SEX PARTNER(S)

- (Mark all that apply)
- Male
 - Female
 - Transgender (M to F)
 - Transgender (F to M)
 - Unknown

CHLAMYDIA

CT DIAGNOSIS (Mark one only)

- Symptomatic - uncomplicated
- Asymptomatic - contact to STD
- Asymptomatic - screening
- Pelvic Inflammatory Disease (PID)
- Conjunctivitis
- Other (specify): _____

SPECIMEN SOURCE (Mark all that apply)

- Cervix
- Vagina
- Urethra
- Rectum
- Pharynx
- Urine
- Other (specify): _____

CT TREATMENT (Mark one only)

- Azithromycin (Zithromax), 1 gm po x 1
- Doxycycline, 100 mg po BID x 7 days
- Erythromycin base, 500 mg po QID x 7 days
- Erythromycin ethylsuccinate, 800 mg po QID x 7 days
- Ofloxacin, 300 mg po BID x 7 days
- Levofloxacin, 500 mg po qd x 7 days
- Other (specify): _____

SPECIMEN COLLECTION DATE (MM DD YYYY)

____/____/____

TREATMENT DATE (MM DD YYYY)

____/____/____

NOT TREATED

GONORRHEA

GC DIAGNOSIS (Mark one only)

- Symptomatic - uncomplicated
- Asymptomatic - contact to STD
- Asymptomatic - screening
- Pelvic Inflammatory Disease (PID)
- Conjunctivitis
- Disseminated
- Other (specify): _____

SPECIMEN SOURCE (Mark all that apply)

- Cervix
- Vagina
- Urethra
- Rectum
- Pharynx
- Urine
- Other (specify): _____

GC TREATMENT (Mark one only)

- Cefixime (Suprax), 400 mg po x 1
- Ceftriaxone (Rocephin), 125 mg IM x 1
- Cefpodoxime (Vantin), 400 mg po x 1
- Spectinomycin, 2g IM x 1
- Other (specify): _____

SPECIMEN COLLECTION DATE (MM DD YYYY)

____/____/____

TREATMENT DATE (MM DD YYYY)

____/____/____

NOT TREATED

ADDITIONAL TREATMENT for Presumptive Chlamydial infection:

- Azithromycin (Zithromax), 1 gm po x 1 (CT presumptive treatment)
- Doxycycline, 100 mg po BID x 7 days (CT presumptive treatment)

SYPHILIS

SYPHILIS DIAGNOSIS (Mark one only)

- Primary Late Latent (≥1 yr)
- Secondary Congenital
- Early Latent (≤1 yr) Other (specify): _____

SYPHILIS TREATMENT (Mark one only)

- Benzathine penicillin G, 2.4 m.u. IM x 1 (early syphilis)
- Benzathine penicillin G, 2.4 m.u. IM weekly x 3 (late latent syphilis)
- Aqueous crystalline penicillin G, 18-24 mu IV x 10-14 days (neuro)
- Other (specify): _____

SPECIMEN COLLECTION DATE (MM DD YYYY)

____/____/____

TREATMENT DATE (MM DD YYYY)

____/____/____

NOT TREATED

NEUROLOGICAL INVOLVEMENT (Mark one only)

- Yes, Confirmed No
- Yes, Probable Unknown

TEST TYPE/RESULTS

- USR _____ RPR _____ VDRL/CSF _____
- FTA _____ TPPA _____ Other (specify): _____

LAB _____

CHANCROID

CHANCROID DIAGNOSIS (lab confirmation or tests to exclude syphilis and herpes) CHANCROID TREATMENT: _____

DIAGNOSED BY:

Physician Last Name _____ First Name _____
 Clinic or Facility _____
 Address _____
 City _____ State _____ Zip _____

FORM COMPLETED BY:

Last Name _____ First Name _____
 Clinic or Facility _____
 Phone Number (____) _____

HE-00760-10
(1/5/2009)

Phone Number (____) _____

MDH USE ONLY:

- LabMatch Call
- Reserve
- Partner

PSU #: _____

IX: _____

730352

MINNESOTA CONFIDENTIAL STD CASE REPORT

Health care providers should use this form to report LAB CONFIRMED cases of sexually transmitted disease as mandated by state law (Minnesota Rules 4605.7040). These diseases are of such major public health concern that surveillance of their occurrence is in the public interest. All case reports are classified as private under the Minnesota Government Data Practices Act (§13.38). Your cooperation in reporting is both encouraged and appreciated.

Laboratory reports do not substitute for physician case reports. Coexisting infections (such as gonorrhea and chlamydia) may be reported on a single form. Do not use this form to report cases of HIV infection. Contact the STD and HIV Section at (651) 201-5414 if you have questions about HIV case reporting.

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MAIL THIS FORM TO: Or for additional information or consultation, contact:

SAMPLE: 1 2 | 3 4 AND X ✓

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
STD and HIV Section
P.O. Box 64975
St. Paul, Minnesota 55164-0975
Telephone: (651) 201-5414
TTY: (651) 201-5797



Please indicate if you would like to receive:

- Additional case report forms
- MDH return envelopes
- STD Treatment Guidelines*
- STD Surveillance Data Summary**
- Partner Services Unit information/brochure**
- STD Reporting Frequently Asked Questions (HIPPA)***

Materials needed by: _____
(date)

* STD Treatment Guidelines are available at: www.cdc.gov/std/treatment/default.htm

** Available at: www.health.state.mn.us/divs/idepc/dtopics/stds/index.html

*** Available at: www.health.state.mn.us/divs/idepc/dtopics/reportable/index.html

IMPORTANT INFORMATION:

Treatment of sexual partners is essential to prevent reinfection and further transmission. All sexual partners who had contact with the patient during the following time periods should be preventively treated, even if the partner's diagnostic tests are negative:

- Chlamydia - 60 days before onset
- Gonorrhea - 60 days before onset
- Syphilis - within 90 days of last exposure to patient

PARTNER SERVICES DATA FOR UNTREATED PARTNERS

Please provide name(s) and locating information for UNTREATED PARTNERS if you would like MDH assistance with partner notification. This information is private and no information that could identify your patient will be revealed to partners.

In most cases, partner follow-up cannot be initiated unless specific locating information is given below. If partners are not followed up with appropriate treatment, reinfection of the patient may occur.

PARTNER'S NAME
ADDRESS
CITY/STATE/ZIP
PHONE NUMBER
RACE/ETHNICITY AGE DATE OF BIRTH SEX
APPROX DATE OF LAST EXPOSURE
PHYSICAL DESCRIPTION ADDITIONAL INFORMATION

PARTNER'S NAME
ADDRESS
CITY/STATE/ZIP
PHONE NUMBER
RACE/ETHNICITY AGE DATE OF BIRTH SEX
APPROX DATE OF LAST EXPOSURE
PHYSICAL DESCRIPTION ADDITIONAL INFORMATION