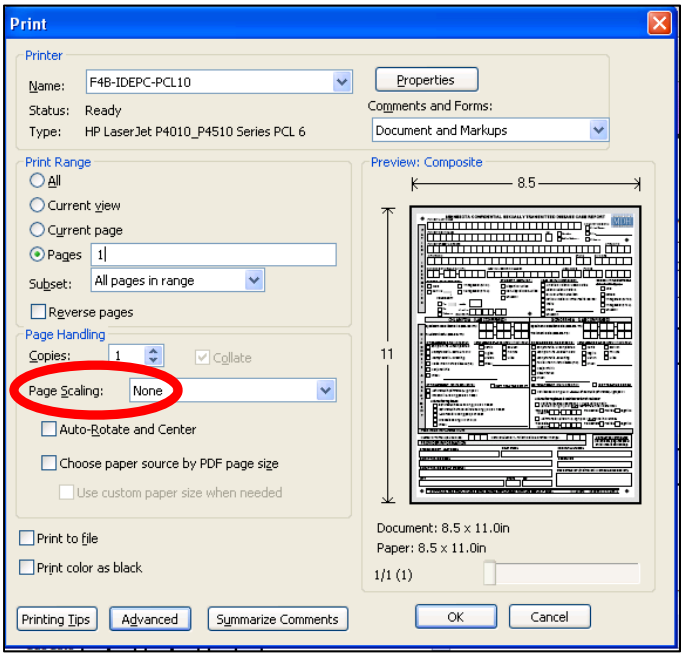
Instructions for Completing the Minnesota Confidential STD Case Report 2013

The following instructions should be used when filling out the Minnesota Confidential STD Case Report form (available at http://www.health.state.mn.us/stdreporting). Health care providers should use this form to report lab confirmed cases of STDs as mandated by State law (Minnesota Rule 4605.7040). All case reports are classified as private under the Minnesota Government Data Practices Act. Laboratory reports do not substitute for physician case reports. Report only lab confirmed cases.

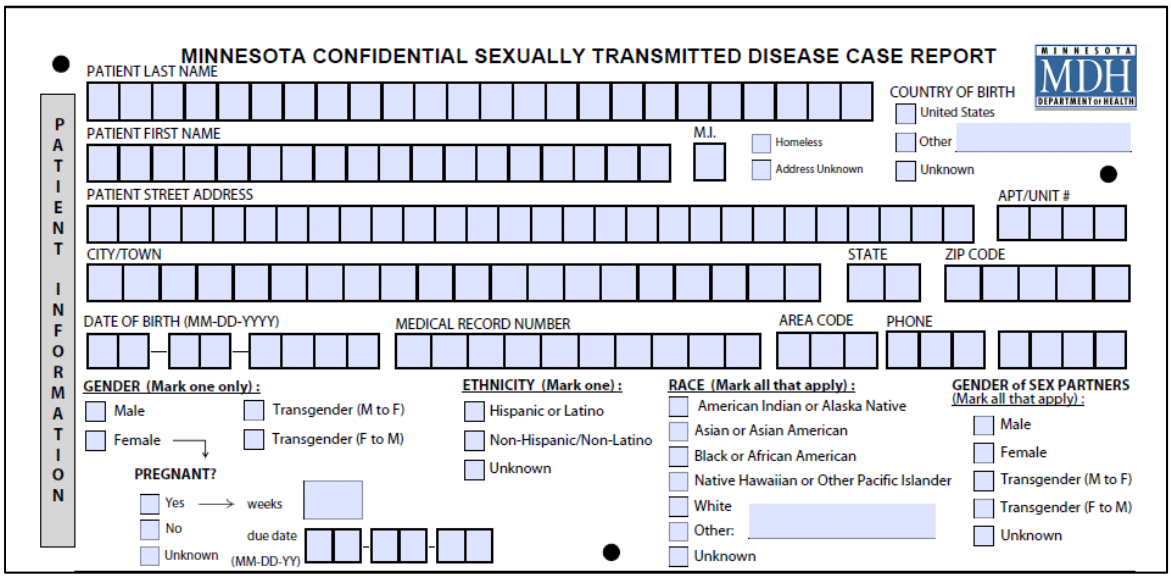
When complete, fax the form to 651-201-4040. No cover sheet is required. If the back page is blank (no untreated partners or not a case of syphilis) it does not have to be submitted. Forms may also be mailed but is not necessary if faxed. Please mark the envelope "confidential" and mail it to MDH at: Infectious Disease Epidemiology, Prevention and Control, 625 North Robert Street, Post Office Box 64975, St. Paul, MN 55164-0975

General Instructions

- Type or print in BOLD CAPITAL LETTERS clearly within the boxes with black ink.
- Tab thru the fields in order, hitting space bar to mark a box.
- Do not touch the sides of the boxes. Fill in the circles or boxes completely or mark with an "X".
- Do not use labels on the form for patient information. Labels or stamps may be used for provider information at the bottom of the form.
- Do not electronically save or email the completed file for data security reasons.
- Print the PDF file on a quality printer.
- Do NOT shrink, scale or reduce the page - set "Page Scaling" to "None" (see example of printer menu below).



Patient Information



PATIENT'S LAST NAME, FIRST NAME, M.I.
Print patient's last name, first name, and middle initials in capital letters.

COUNTRY OF BIRTH
Mark the patient's country of birth. "United States" refers to the continental United States, Hawaii, or Alaska. "Other" refers to any other country, including a U.S. dependency or possession (e.g., Puerto Rico). If "Other" is marked, print the name of the country in capital letters on the line provided.

ADDRESS, APT/UNIT NUMBER, CITY/TOWN, STATE
Print patient's street address of residence at the time of specimen collection. If the patient is homeless or the address is unknown, leave the boxes blank and mark the appropriate box to the right of patient name.

ZIP CODE
Enter the patient's five-digit zip code of residence at the time of specimen collection. If the patient is homeless or the address is unknown, leave the boxes blank and mark the appropriate box to the right of patient name.

DATE OF BIRTH
Print the patient's date of birth in the numerical MM-DD-YYYY format. For example, if the patient was born on January 15, 1975, print "01-15-1975".

MEDICAL RECORD NUMBER
Print the patient's medical record number.

AREA CODE, PHONE NUMBER
Print the patient's area code and phone number.

GENDER
Mark the patient's gender. Mark only one.

PREGNANT
If the patient is female, mark her pregnancy status at the time of specimen collection and if known write in the number of weeks in the pregnancy and due date.

ETHNICITY
Mark the patient's ethnicity as reported by the patient. Mark only one.
Based on the federal 1997 OMB Directive 15, the definition of the first category is:

"Hispanic or Latino" -- A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

RACE
Mark one or more racial designations as reported by the patient. If "Other" is marked, print the patient's self-reported race in capital letters on the line provided. Based on the federal 1997 OMB Directive 15, the definitions of the categories are:

"American Indian or Alaska Native" -- A person having origins in any of the original peoples of North and South America (including Central America), and who maintains a tribal affiliation or community attachment.

"Asian" – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippines Islands, Thailand, and Vietnam.

"Black or African American" – A person having origins in any of the black racial groups of Africa.

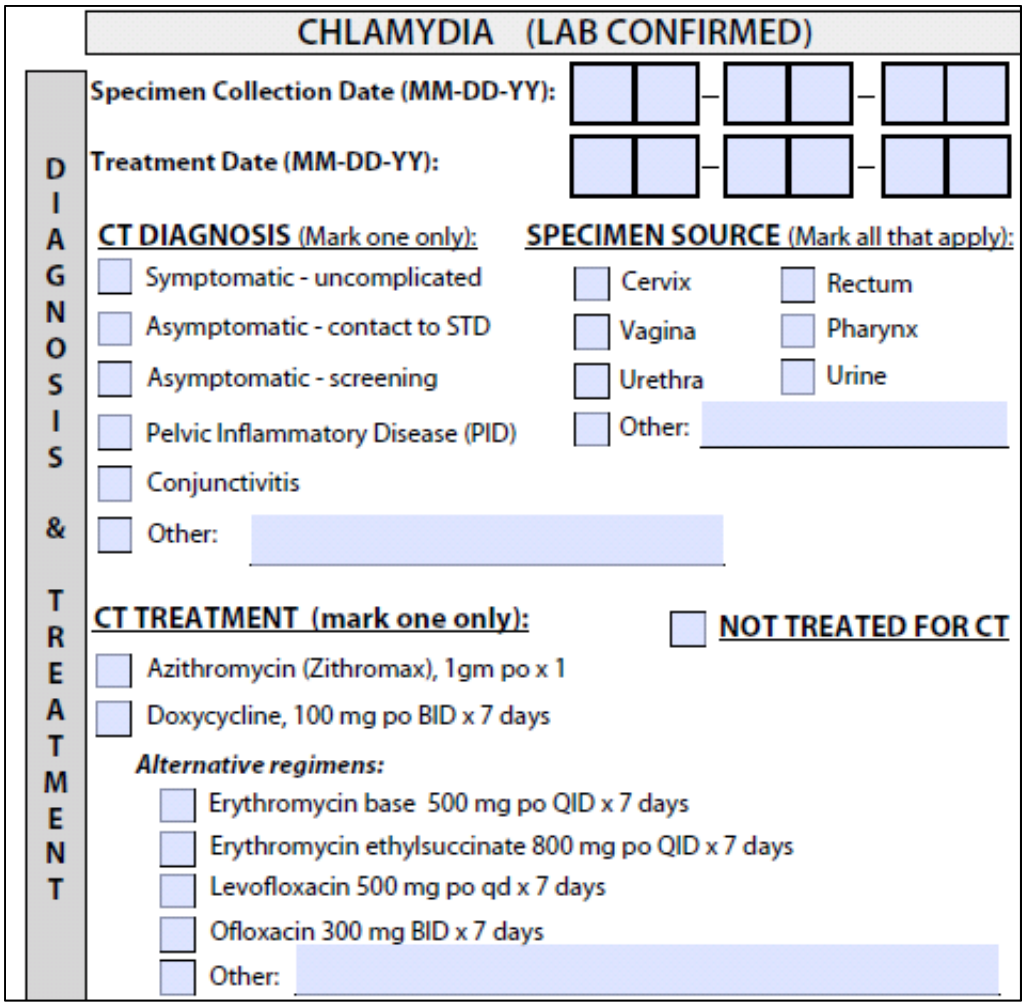
"Native Hawaiian or Other Pacific Islander" – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

"White" – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

GENDER OF SEX PARTNERS
Mark the gender(s) of the patient's sex partner(s). Mark all that apply. Include all sexual partners who had contact with the patient during the following time periods:

- Chlamydia – 60 days preceding onset of symptoms or diagnosis of chlamydia in patient
- Gonorrhea – 60 days preceding onset of symptoms or diagnosis of gonorrhea in patient
- Syphilis –12 months preceding diagnosis of primary, secondary, or early latent syphilis

For reporting a laboratory-confirmed chlamydia case:



SPECIMEN COLLECTION DATE
Print the date the specimen was collected in the numerical MMDDYY format. For example, if specimen was collected on May 1, 2013, then print "05-01-13"

CT TREATMENT DATE
Print the date the patient was treated for the laboratory-confirmed chlamydial infection in the numerical MMDDYY format. If the patient was not treated, mark the box "NOT TREATED" and print an explanation in the blank space below the question.

CT DIAGNOSIS
Mark the laboratory-confirmed chlamydia diagnosis. Mark only one.

SPECIMEN SOURCE
Mark the source of the specimen used for chlamydia testing. Mark all that apply. If "Other" is marked, print the site in capital letters on the line provided.

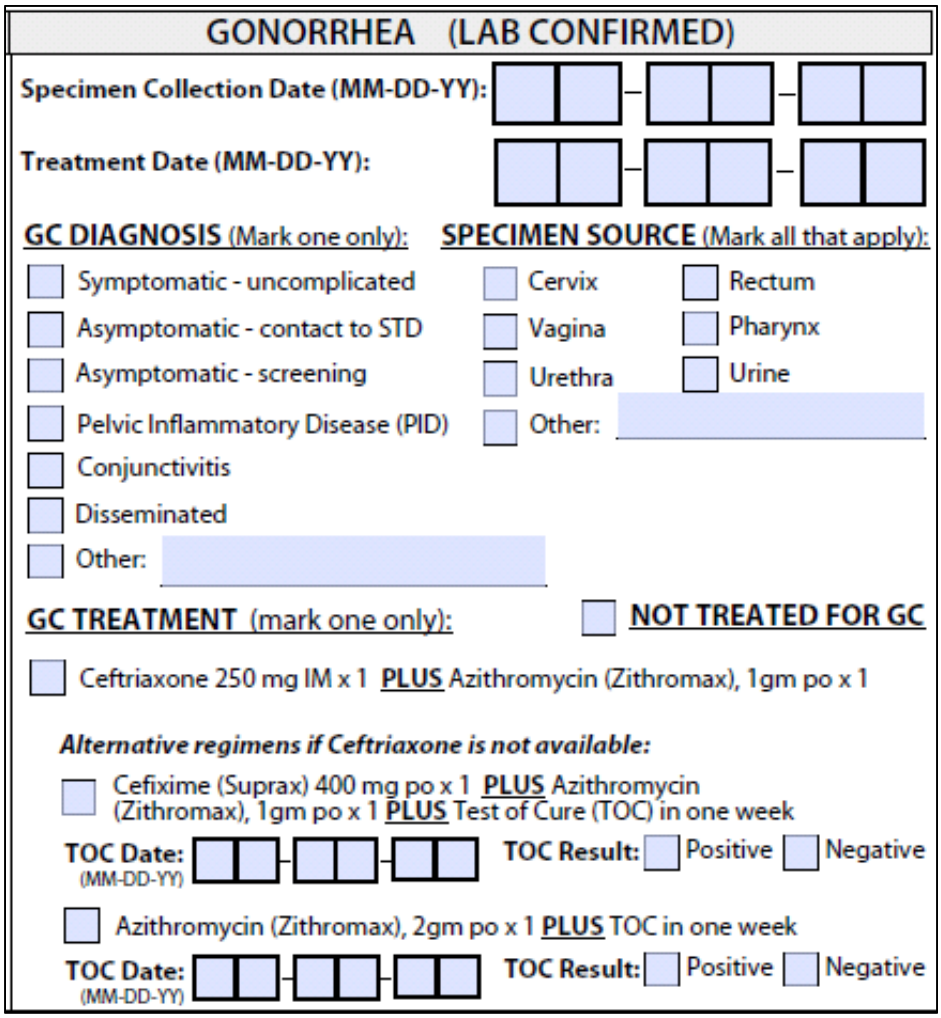
CT TREATMENT

Mark the treatment(s) administered to the patient for the laboratory-confirmed chlamydia diagnosis. Mark all that apply. If “Other” is marked, print the name of the medication and the dosage on the line provided. (See: CDC's STD Treatment Guidelines: Chlamydial Infections)

- Azithromycin (Zithromax®) 1 g orally in a single dose
- Doxycycline (Doxy®) 100 mg orally twice a day for 7 days
- Erythromycin base 500 mg orally four times a day for 7 days
- Erythromycin ethylsuccinate 800 mg orally four times a day for 7 days
- Ofloxacin (Floxin®) 300 mg orally twice a day for 7 days
- Levofloxacin (Levaquin®) 500 mg orally once daily for 7 days

Note: If the patient is a laboratory-confirmed gonorrhea case that received dual therapy without a laboratory-confirmed chlamydia diagnosis, DO NOT mark the presumptive chlamydia treatment in this section. Instead, report the presumptive treatment within the GONORRHEA section.

For reporting a laboratory-confirmed gonorrhea case:


GONORRHEA (LAB CONFIRMED)

Specimen Collection Date (MM-DD-YY): ☐☐–☐☐–☐☐

Treatment Date (MM-DD-YY): ☐☐–☐☐–☐☐

GC DIAGNOSIS (Mark one only):

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

SPECIMEN SOURCE (Mark all that apply):

- ☐ Cervix
- ☐ Vagina
- ☐ Urethra
- ☐ Other:
- ☐ Rectum
- ☐ Pharynx
- ☐ Urine

GC TREATMENT (mark one only):

☐ NOT TREATED FOR GC

☐ Ceftriaxone 250 mg IM x 1 PLUS Azithromycin (Zithromax), 1gm po x 1

Alternative regimens if Ceftriaxone is not available:

☐ Cefixime (Suprax) 400 mg po x 1 PLUS Azithromycin (Zithromax), 1gm po x 1 PLUS Test of Cure (TOC) in one week

TOC Date: (MM-DD-YY) ☐☐-☐☐-☐☐ TOC Result: ☐ Positive ☐ Negative

☐ Azithromycin (Zithromax), 2gm po x 1 PLUS TOC in one week

TOC Date: (MM-DD-YY) ☐☐-☐☐-☐☐ TOC Result: ☐ Positive ☐ Negative

SPECIMEN COLLECTION DATE
Print the date the specimen was collected in the numerical MM-DD-YY format. For example, if specimen was collected on May 1, 2013, then print “05-01-13”

GC TREATMENT DATE
Print the date the patient was treated for the laboratory-confirmed gonorrhea infection in the numerical MM-DD-YY format. If the patient was not treated, mark the box “NOT TREATED” and print an explanation in the blank space below the question.

GC DIAGNOSIS
Mark the laboratory-confirmed gonorrhea diagnosis. Mark only one.

SPECIMEN SOURCE
Mark the source of the specimen used for gonorrhea testing. Mark all that apply. If “Other” is marked, print the site in capital letters on the line provided.

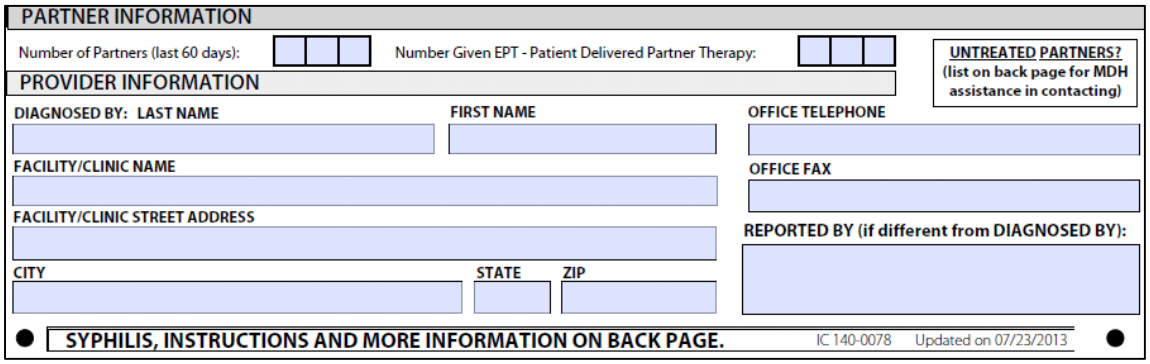
GC TREATMENT
Mark the treatment(s) administered to the patient for the laboratory-confirmed gonorrhea diagnosis. Mark all that apply. If "Other" is marked, enter the name of the medication and the dosage on the line provided. (See: CDC's STD Treatment Guidelines: Gonococcal Infections)

- Ceftriaxone (Rocephin®) 250 mg in a single intramuscular dose PLUS Azithromycin (Zithromax®) 1 g orally in a single dose OR Doxycycline (Doxy®) 100 mg orally twice a day for 7 days
  (Because of the high prevalence of tetracycline resistance among Gonococcal Isolate Surveillance Project isolates, particularly those with elevated minimum inhibitory concentrations to cefixime, the use of azithromycin as the second antimicrobial is preferred.)

  - Alternative regimens If Ceftriaxone (Rocephin®) is not available:
    Cefixime 400 mg in a single oral dose PLUS Azithromycin (Zithromax®) 1 g orally in a single dose OR Doxycycline (Doxy®) 100 mg orally twice a day for 7 days PLUS Test-of-cure in 1 week
    (Because of the high prevalence of tetracycline resistance among Gonococcal Isolate Surveillance Project isolates, particularly those with elevated minimum inhibitory concentrations to cefixime, the use of azithromycin as the second antimicrobial is preferred.)

  - If the patient has severe cephalosporin allergy:
    Azithromycin (Zithromax®) 2 g in a single oral dose PLUS Test-of-cure in 1 week

Partner Information

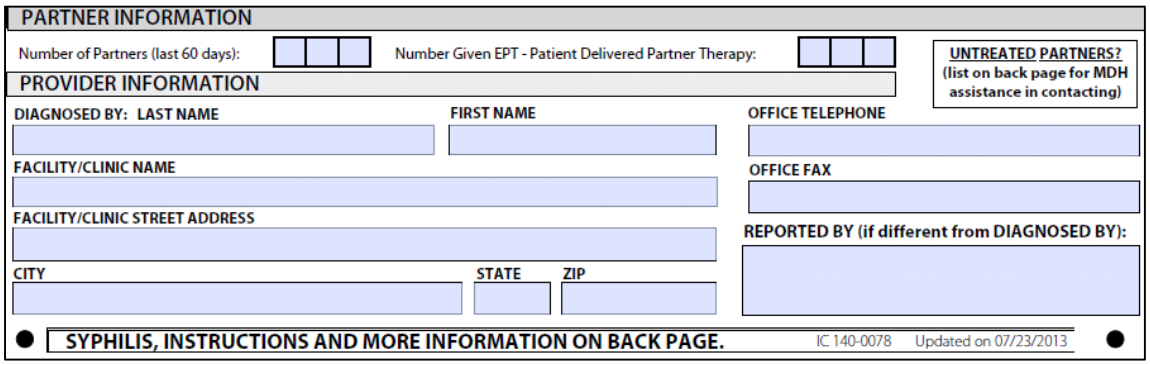

PARTNER INFORMATION
Number of Partners (last 60 days):
Number Given EPT - Patient Delivered Partner Therapy:
UNTREATED PARTNERS? (list on back page for MDH assistance in contacting)
PROVIDER INFORMATION
DIAGNOSED BY: LAST NAME
FIRST NAME
OFFICE TELEPHONE
FACILITY/CLINIC NAME
OFFICE FAX
FACILITY/CLINIC STREET ADDRESS
REPORTED BY (if different from DIAGNOSED BY):
CITY
STATE
ZIP
SYPHILIS, INSTRUCTIONS AND MORE INFORMATION ON BACK PAGE.
IC 140-0078 Updated on 07/23/2013

Number of Partners: Complete the number of the partners the patient had contact with the patient in the last 60 days.

Partners Given Expedited Partner Therapy (EPT)/Patient Delivered Therapy (PDT)

Complete the number of the partners who received EPT/PDT from the patient.

Provider Information


PARTNER INFORMATION

Number of Partners (last 60 days):

Number Given EPT - Patient Delivered Partner Therapy:

UNTREATED PARTNERS? (list on back page for MDH assistance in contacting)

PROVIDER INFORMATION

DIAGNOSED BY: LAST NAME

FIRST NAME

OFFICE TELEPHONE

FACILITY/CLINIC NAME

OFFICE FAX

FACILITY/CLINIC STREET ADDRESS

REPORTED BY (if different from DIAGNOSED BY):

CITY

STATE

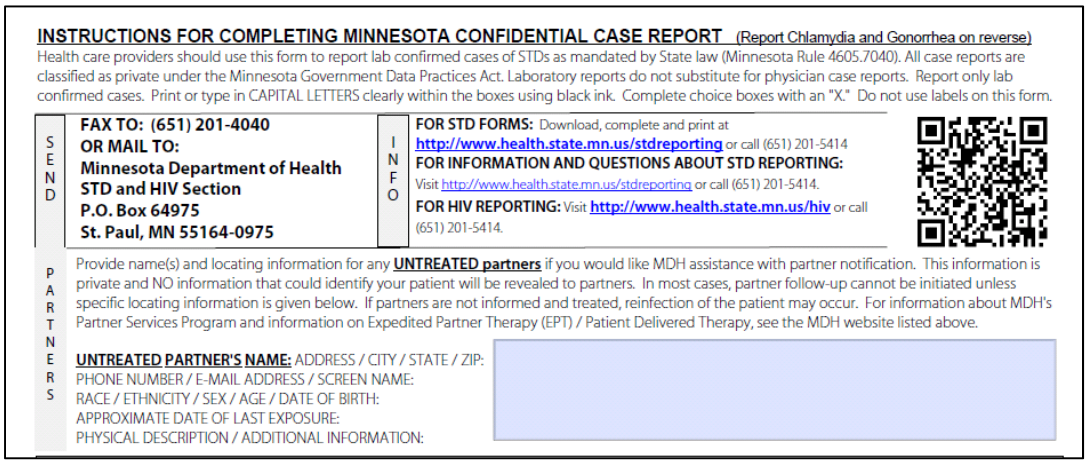
ZIP

SYPHILIS, INSTRUCTIONS AND MORE INFORMATION ON BACK PAGE. IC 140-0078 Updated on 07/23/2013

DIAGNOSED BY:
Print diagnosing physician's last name, physician's first name, clinic name, clinic address, phone number and fax number. A label or stamp may be used in this area.

REPORTED BY:
Print the last name, first name of the person completing the case report form, as well as the clinic name and phone number of the reporting facility.

Back of Form


INSTRUCTIONS FOR COMPLETING MINNESOTA CONFIDENTIAL CASE REPORT (Report Chlamydia and Gonorrhea on reverse)

Health care providers should use this form to report lab confirmed cases of STDs as mandated by State law (Minnesota Rule 4605.7040). All case reports are classified as private under the Minnesota Government Data Practices Act. Laboratory reports do not substitute for physician case reports. Report only lab confirmed cases. Print or type in CAPITAL LETTERS clearly within the boxes using black ink. Complete choice boxes with an "X." Do not use labels on this form.

SEND

FAX TO: (651) 201-4040
OR MAIL TO:
Minnesota Department of Health
STD and HIV Section
P.O. Box 64975
St. Paul, MN 55164-0975

INFO

FOR STD FORMS: Download, complete and print at http://www.health.state.mn.us/stdreporting or call (651) 201-5414
FOR INFORMATION AND QUESTIONS ABOUT STD REPORTING: Visit http://www.health.state.mn.us/stdreporting or call (651) 201-5414.
FOR HIV REPORTING: Visit http://www.health.state.mn.us/hiv or call (651) 201-5414.

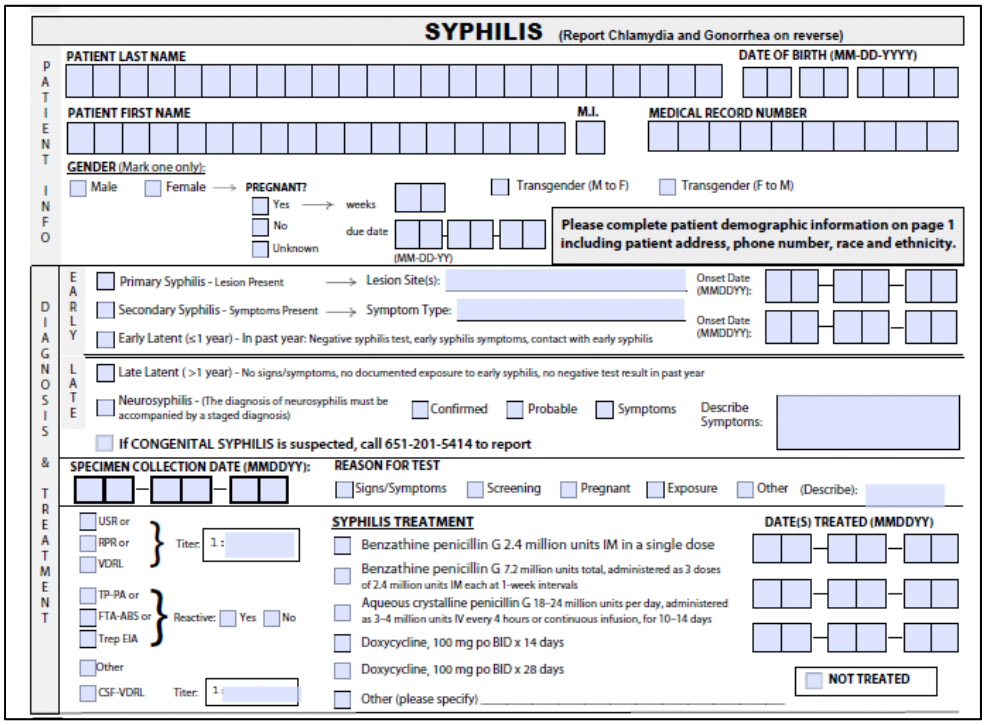
PARTNERS

Provide name(s) and locating information for any 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 informed and treated, reinfection of the patient may occur. For information about MDH's Partner Services Program and information on Expedited Partner Therapy (EPT) / Patient Delivered Therapy, see the MDH website listed above.

UNTREATED PARTNER'S NAME: ADDRESS / CITY / STATE / ZIP:
PHONE NUMBER / E-MAIL ADDRESS / SCREEN NAME:
RACE / ETHNICITY / SEX / AGE / DATE OF BIRTH:
APPROXIMATE DATE OF LAST EXPOSURE:
PHYSICAL DESCRIPTION / ADDITIONAL INFORMATION:

UNTREATED PARTNERS
If you would like MDH Partner Services assistance with private partner notification, enter the name(s) and complete locating information of UNTREATED PARTNERS within the last 60 days for gonorrhea and chlamydia and within the last 90 days for syphilis.

For reporting a laboratory-confirmed syphilis case:



SYPHILIS DIAGNOSIS
Mark the laboratory-confirmed syphilis diagnosis. Mark only one.

SYPHILIS TREATMENT
Mark the treatment(s) administered to the patient for the laboratory-confirmed syphilis diagnosis. Mark all that apply. If "Other" is marked, enter the name of the medication and the dosage on the line provided.

SPECIMEN COLLECTION DATE
Print the date the specimen was collected in the numerical MM-DD-YY format. For example, if specimen was collected on May 1, 2013, then print "05-01-13"

TREATMENT DATE
Print the date the patient was treated for the laboratory-confirmed syphilis infection in the numerical MM-DD-YY format. If the patient was not treated, mark the circle "NOT TREATED" and print an explanation in the blank space below the question.

TEST TYPE / RESULTS
Mark the circle corresponding to the type of test(s) performed and print the result (e.g., titer) on the line provided.

LAB
Print the name of the laboratory that performed the diagnostic test on the line provided.

For reporting a chancroid case:

To report a case of chancroid, please call (651) 201-5414.