

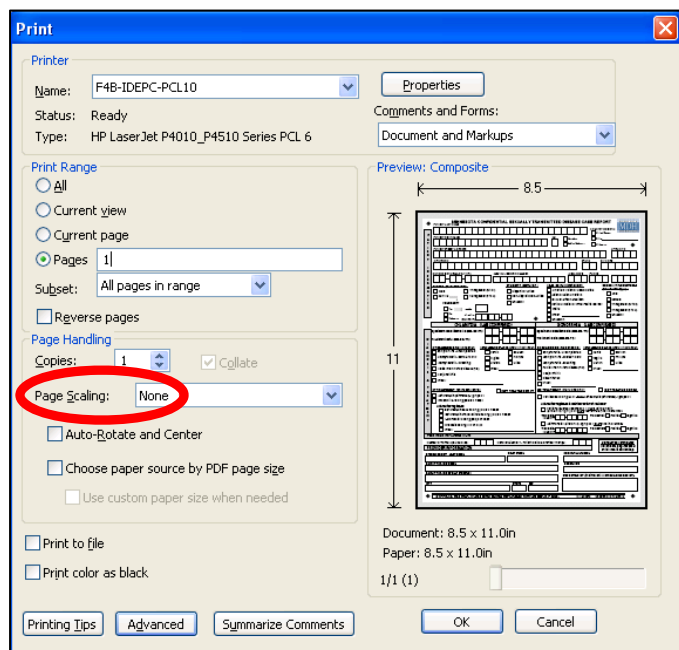
## Instructions for Completing the Minnesota Confidential STD Case Report 2013

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

MINNESOTA CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT										MINNESOTA MDH DEPARTMENT OF HEALTH		
P A T I E N T  I N F O R M A T I O N	PATIENT LAST NAME										COUNTRY OF BIRTH	
	<input type="text"/>										<input type="checkbox"/> United States	
	PATIENT FIRST NAME										<input type="checkbox"/> Other <input type="text"/>	
	M.I.										<input type="checkbox"/> Homeless	
	<input type="text"/>										<input type="checkbox"/> Address Unknown	
	<input type="text"/>										<input type="checkbox"/> Unknown	
	PATIENT STREET ADDRESS										APT/UNIT #	
	<input type="text"/>										<input type="text"/>	
	CITY/TOWN										STATE	
	<input type="text"/>										<input type="text"/>	
DATE OF BIRTH (MM-DD-YYYY)			MEDICAL RECORD NUMBER				AREA CODE		PHONE			
<input type="text"/>			<input type="text"/>				<input type="text"/>		<input type="text"/>			
GENDER (Mark one only):			ETHNICITY (Mark one):				RACE (Mark all that apply):			GENDER of SEX PARTNERS (Mark all that apply):		
<input type="checkbox"/> Male			<input type="checkbox"/> Hispanic or Latino				<input type="checkbox"/> American Indian or Alaska Native			<input type="checkbox"/> Male		
<input type="checkbox"/> Female			<input type="checkbox"/> Non-Hispanic/Non-Latino				<input type="checkbox"/> Asian or Asian American			<input type="checkbox"/> Female		
<input type="checkbox"/> Transgender (M to F)			<input type="checkbox"/> Unknown				<input type="checkbox"/> Black or African American			<input type="checkbox"/> Transgender (M to F)		
<input type="checkbox"/> Transgender (F to M)							<input type="checkbox"/> Native Hawaiian or Other Pacific Islander			<input type="checkbox"/> Transgender (F to M)		
PREGNANT?							<input type="checkbox"/> White			<input type="checkbox"/> Unknown		
<input type="checkbox"/> Yes							<input type="checkbox"/> Other: <input type="text"/>					
<input type="checkbox"/> No							<input type="checkbox"/> Unknown					
<input type="checkbox"/> Unknown												
weeks <input type="text"/>												
due date (MM-DD-YY) <input type="text"/>												

### **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:**

CHLAMYDIA (LAB CONFIRMED)	
D I A G N O S I S & T R E A T M E N T	Specimen Collection Date (MM-DD-YY): <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
	Treatment Date (MM-DD-YY): <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
	<b>CT DIAGNOSIS (Mark one only):</b>
	<input type="checkbox"/> Symptomatic - uncomplicated
	<input type="checkbox"/> Asymptomatic - contact to STD
	<input type="checkbox"/> Asymptomatic - screening
	<input type="checkbox"/> Pelvic Inflammatory Disease (PID)
	<input type="checkbox"/> Conjunctivitis
	<input type="checkbox"/> Other: <input type="text"/>
	<b>SPECIMEN SOURCE (Mark all that apply):</b>
<input type="checkbox"/> Cervix	
<input type="checkbox"/> Rectum	
<input type="checkbox"/> Vagina	
<input type="checkbox"/> Pharynx	
<input type="checkbox"/> Urethra	
<input type="checkbox"/> Urine	
<input type="checkbox"/> Other: <input type="text"/>	
<b>CT TREATMENT (mark one only):</b>	
<input type="checkbox"/> NOT TREATED FOR CT	
<input type="checkbox"/> Azithromycin (Zithromax), 1gm po x 1	
<input type="checkbox"/> Doxycycline, 100 mg po BID x 7 days	
<b>Alternative regimens:</b>	
<input type="checkbox"/> Erythromycin base 500 mg po QID x 7 days	
<input type="checkbox"/> Erythromycin ethylsuccinate 800 mg po QID x 7 days	
<input type="checkbox"/> Levofloxacin 500 mg po qd x 7 days	
<input type="checkbox"/> Ofloxacin 300 mg BID x 7 days	
<input type="checkbox"/> Other: <input type="text"/>	

**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):	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
Treatment Date (MM-DD-YY):	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
<b>GC DIAGNOSIS</b> (Mark one only):	<b>SPECIMEN SOURCE</b> (Mark all that apply):
<input type="checkbox"/> Symptomatic - uncomplicated	<input type="checkbox"/> Cervix <input type="checkbox"/> Rectum
<input type="checkbox"/> Asymptomatic - contact to STD	<input type="checkbox"/> Vagina <input type="checkbox"/> Pharynx
<input type="checkbox"/> Asymptomatic - screening	<input type="checkbox"/> Urethra <input type="checkbox"/> Urine
<input type="checkbox"/> Pelvic Inflammatory Disease (PID)	<input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Conjunctivitis	
<input type="checkbox"/> Disseminated	
<input type="checkbox"/> Other: <input type="text"/>	
<b>GC TREATMENT</b> (mark one only):	<input type="checkbox"/> <b>NOT TREATED FOR GC</b>
<input type="checkbox"/> Ceftriaxone 250 mg IM x 1 <b>PLUS</b> Azithromycin (Zithromax), 1 gm po x 1	
<b>Alternative regimens if Ceftriaxone is not available:</b>	
<input type="checkbox"/> Cefixime (Suprax) 400 mg po x 1 <b>PLUS</b> Azithromycin (Zithromax), 1 gm po x 1 <b>PLUS</b> Test of Cure (TOC) in one week	
TOC Date: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	TOC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<input type="checkbox"/> Azithromycin (Zithromax), 2 gm po x 1 <b>PLUS</b> TOC in one week	
TOC Date: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	TOC Result: <input type="checkbox"/> Positive <input type="checkbox"/> 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):	<input type="text"/>	Number Given EPT - Patient Delivered Partner Therapy: <input type="text"/>
PROVIDER INFORMATION		<b>UNTREATED PARTNERS?</b> (list on back page for MDH assistance in contacting)
DIAGNOSED BY: LAST NAME	FIRST NAME	OFFICE TELEPHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>
FACILITY/CLINIC NAME		OFFICE FAX
<input type="text"/>		<input type="text"/>
FACILITY/CLINIC STREET ADDRESS		REPORTED BY (if different from DIAGNOSED BY):
<input type="text"/>		<input type="text"/>
CITY	STATE	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>
● <b>SYPHILIS, INSTRUCTIONS AND MORE INFORMATION ON BACK PAGE.</b> 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

<b>PARTNER INFORMATION</b>		
Number of Partners (last 60 days):	<input type="text"/>	Number Given EPT - Patient Delivered Partner Therapy: <input type="text"/>
<b>PROVIDER INFORMATION</b>		
DIAGNOSED BY: LAST NAME	FIRST NAME	OFFICE TELEPHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>
FACILITY/CLINIC NAME	OFFICE FAX	
<input type="text"/>	<input type="text"/>	
FACILITY/CLINIC STREET ADDRESS	REPORTED BY (if different from DIAGNOSED BY):	
<input type="text"/>	<input type="text"/>	
CITY	STATE	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>
● <b>SYPHILIS, INSTRUCTIONS AND MORE INFORMATION ON BACK PAGE.</b> IC 140-0078 Updated on 07/23/2013 ●		

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


### 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

<b>INSTRUCTIONS FOR COMPLETING MINNESOTA CONFIDENTIAL CASE REPORT</b> (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.		
S E N D	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	FOR STD FORMS: Download, complete and print at <a href="http://www.health.state.mn.us/stdreporting">http://www.health.state.mn.us/stdreporting</a> or call (651) 201-5414 FOR INFORMATION AND QUESTIONS ABOUT STD REPORTING: Visit <a href="http://www.health.state.mn.us/stdreporting">http://www.health.state.mn.us/stdreporting</a> or call (651) 201-5414. FOR HIV REPORTING: Visit <a href="http://www.health.state.mn.us/hiv">http://www.health.state.mn.us/hiv</a> or call (651) 201-5414.
		
P A R T N E R S	Provide name(s) and locating information for any <b>UNTREATED partners</b> 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:	<input type="text"/>

### 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:

P A T I E N T I N F O	
<b>SYPHILIS</b> (Report Chlamydia and Gonorrhea on reverse)	
PATIENT LAST NAME	DATE OF BIRTH (MM-DD-YYYY)
PATIENT FIRST NAME	M.I. MEDICAL RECORD NUMBER
GENDER (Mark one only): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (M to F) <input type="checkbox"/> Transgender (F to M)	
PREGNANT? <input type="checkbox"/> Yes → weeks <input type="checkbox"/> No due date (MM-DD-YY) <input type="checkbox"/> Unknown	
Please complete patient demographic information on page 1 including patient address, phone number, race and ethnicity.	
E A R L Y L A T E N T S	
<input type="checkbox"/> Primary Syphilis - Lesion Present → Lesion Site(s):	Onset Date (MMDDYY):
<input type="checkbox"/> Secondary Syphilis - Symptoms Present → Symptom Type:	Onset Date (MMDDYY):
<input type="checkbox"/> Early Latent (<1 year) - In past year: Negative syphilis test, early syphilis symptoms, contact with early syphilis	
<input type="checkbox"/> Late Latent (>1 year) - No signs/symptoms, no documented exposure to early syphilis, no negative test result in past year	
<input type="checkbox"/> Neurosyphilis - (The diagnosis of neurosyphilis must be accompanied by a staged diagnosis) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Symptoms Describe Symptoms:	
<input type="checkbox"/> If CONGENITAL SYPHILIS is suspected, call 651-201-5414 to report	
S P E C I M E N C O L L E C T I O N D A T E (MMDDYY):	
REASON FOR TEST: <input type="checkbox"/> Signs/Symptoms <input type="checkbox"/> Screening <input type="checkbox"/> Pregnant <input type="checkbox"/> Exposure <input type="checkbox"/> Other (Describe):	
SYNOPSIS	
USR or RPR or VDRL } Titer: 1:	DATE(S) TREATED (MMDDYY)
TP-PA or FTA-ABS or Trep EIA } Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other } Titer: 1:	
CSF-VDRL } Titer: 1:	
SYNOPSIS TREATMENT	
<input type="checkbox"/> Benzathine penicillin G 2.4 million units IM in a single dose	
<input type="checkbox"/> Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals	
<input type="checkbox"/> Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion, for 10-14 days	
<input type="checkbox"/> Doxycycline, 100 mg po BID x 14 days	
<input type="checkbox"/> Doxycycline, 100 mg po BID x 28 days	
<input type="checkbox"/> Other (please specify)	
<input type="checkbox"/> NOT TREATED	

### 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.