Washington County Department of Health and Human Services

Return completed form to Washington County Public Health Disease Control and Prevention
FAX: 503-846-3644 ◆ Call with questions: 503-846-2972

STI Case Reporting Form for Chlamydia and Gonorrhea

Clinic Information

Date:	Person Completing Form:
Health Provider:	Contact phone number/fax:

Your lab reported a communicable disease on the patient shown below and listed you as the provider. The Oregon Department of Human Services and Washington County require additional information. The fax cover sheet you have received references Oregon Law (ORS 433) that requires you to report this information.

Please complete the form within 24 hours, or by the end of the next working day, and fax it back to our office at 503-846-3644. If you prefer you may call to report the required information. We appreciate your cooperation and prompt handling of this confidential report.

Patient Information — Please complete all information requested below

1 **NAME:** | **DATE OF BIRTH:** | **GENDER:** ☐ Male ☐ Female ☐ Other

2 **HOME ADDRESS:**

________________________ street ________________________ city/state __________ zip

PHONE NUMBER: _______ – _______ – __________ **ALTERNATIVE # :** _______ – _______ – __________

3 **PREGNANCT TEST RESULTS:** ☐ N/A ☐ Negative ☐ Unknown ☐ Positive: **If positive h**ow many weeks? _________

4 **ETHNICITY:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan ☐ Pacific Islander ☐ Unknown ☐ Other: __________

GENDER OF SEX PARTNER(S): ☐ Male ☐ Female ☐ Both ☐ Unknown

5 **TEST RESULT TYPE:**
☐ Chlamydia Positive Result DATE________________
☐ Gonorrhea Positive Result DATE:________________

PREVIOUS HIV TESTING: ☐ Yes ☐ No ☐ Unknown
If yes, last result was? ☐ POS ☐ NEG ☐ Unknown
Month of last test ________________ Year of last test _________

6 **REASON FOR EXAM:**
☐ Symptomatic
☐ Routine Exam
☐ Test for Cure
☐ Exposed to Infection
☐ Pregnant

DIAGNOSIS:
☐ Asymptomatic
☐ Symptomatic-Uncomplicated
☐ Pelvic Inflammatory Disease (PID)
☐ Ophthalmia /conjunctivitis
☐ Disseminated

SITE(S):
☐ Cervix ☐ Ocular
☐ Vaginal ☐ Urine
☐ Urethra ☐ Pharynx
☐ Rectum ☐ Other:

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GONORRHEA TREATMENT PLAN:

☐ Rocephin/Ceftriaxone 250mg IM x 1.
Date______________

PLUS

☐ Azithromycin 1gm orally in a single dose.

Alternative Treatment Regimens

☐ Cefixime 400mg orally in a single dose Date ____________

PLUS

☐ Azithromycin 1 gm orally in a single dose

☐ Other Treatment: DATE:_____________

____

(test of cure recommended at 1 month)

CHLAMYDIA TREATMENT PLAN:

☐ Azithromycin 1gm orally in a single dose. Date :_______

OR

☐ Doxycycline 100mg BID x 7 days. Date : _____________
(contraindicated during pregnancy)

Alternative Treatment Regimens

☐ Amoxicillin 500mg orally tid X 7 days Date:______________

☐ Other Treatment: Date:______________

____

8 **IF NOT TREATED YET — PATIENT NOTIFIED OF INFECTION:** ☐ Yes ☐ No
Does the provider need assistance in contacting a client that has not responded for treatment? ☐ Yes ☐ No

9. PARTNER MANAGEMENT PLAN — Ensuring Partner Treatment

Expedited Partner Therapy dispensed at time of visit? ☐ No ☐ YES: How many partners? __________.
(See: OHA/STD Prevention for EPT guidelines and policy).

When resources allow the health department will be contacting gonorrhea cases and high risk chlamydia cases to offer partner services.
Please notify patient that public health worker may be contacting them to offer partner services.
☐ PROVIDER REQUESTS THAT CLIENT NOT BE CONTACTED BY PUBLIC HEALTH/PROVIDER WILL ASSURE PARTNER TREATMENT

CURRENT RECOMMENDED TREATMENT- See CDC Guidelines at: www.cdc.gov/std/treatment/