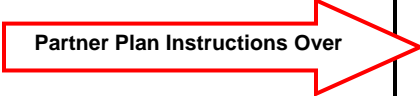


CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT

Report STDs within three work days. (WAC 246-101-101/301)

PATIENT INFORMATION					
LAST NAME		FIRST NAME			MIDDLE INITIAL
ADDRESS		TELEPHONE ()	REASON FOR EXAM (Check one)		
CITY/TOWN		STATE	ZIP CODE	<input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam – No Symptoms <input type="checkbox"/> Exposed to Infection	
DATE OF DIAGNOSIS		SEX		DATE OF BIRTH	
MO	DAY	YR	<input type="checkbox"/> Male <input type="checkbox"/> Female	MO	DAY
ETHNICITY		RACE – Check all that apply		GENDER OF SEX PARTNERS	
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander		<input type="checkbox"/> Male <input type="checkbox"/> Both <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
DIAGNOSIS – DISEASE					
GONORRHEA (lab confirmed) DIAGNOSIS - ✓ only one <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: _____			SITE(S) - ✓ all that apply <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"/> Other: _____		TREATMENT - ✓ all prescribed <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Cefixime <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____ DATE RX: _____
			SYPHILIS <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"/> Congenital <input type="checkbox"/> Neurosyphillis <input type="checkbox"/> Late RX GIVEN: _____ DATE RX: _____		
CHLAMYDIA TRACHOMATIS (lab confirmed) DIAGNOSIS - ✓ only one <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: _____			SITE(S) - ✓ all that apply <input type="checkbox"/> Cervix <input type="checkbox"/> Rectum <input type="checkbox"/> Urethra <input type="checkbox"/> Pharynx <input type="checkbox"/> Urine <input type="checkbox"/> Vagina <input type="checkbox"/> Other: _____		TREATMENT - ✓ all prescribed <input type="checkbox"/> Azithromycin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Other: _____ DATE RX: _____
			HERPES SIMPLEX <input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal Laboratory Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No OTHER <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"/> Health Department to assume responsibility for partner treatment. <i>Health Department assistance recommended if:</i> <ul style="list-style-type: none"> • Patient has had 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 or unwilling to contact one or more partner, or • Patient is a man who has sex with other men. <i>Note: You may also choose this option if you are providing partner treatment for one or more partners (free meds available) and would like Health Department assistance for additional partners.</i>					
2. <input type="checkbox"/> Provider will ensure <u>all</u> partners treated (FREE medications available). Indicate number to be treated (_____).					
3. <input type="checkbox"/> All partners have been treated. Indicate number treated (_____).					
REPORTING CLINIC INFORMATION					
DATE		DIAGNOSING CLINICIAN			
FACILITY NAME		PERSON COMPLETING FORM			
ADDRESS		TELEPHONE			
CITY	STATE	EMAIL			



Thank you for reporting an STD. All information will be managed with the strictest confidentiality.

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 Whatcom County Health Department 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 **Whatcom County Health Department: 360-676-6724, ext 30696.**

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

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

The Whatcom County Health Department 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 Whatcom County Health Department: 360-676-6724, ext 30696.

Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV or granuloma inguinale are routinely contacted by Whatcom County Health Department. 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):

Ceftriaxone250 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

Doxycycline100 mg PO BID for 7 days

Alternatives:

Erythromycin(base) 500 mg PO QID for 7 days,

OR (ethylsuccinate) 800 mg PO QID for 7 days, **OR**

Ofloxacin300 mg PO BID for 7 days,

OR

Levofloxacin500 mg PO for 7 days

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 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:

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

Indicate (✓) Pharmacy To Dispense Medications - Participating Pharmacies in Whatcom County				
✓	Pharmacy Name	Fax #	Address	Phone
	Rite Aid #5239	360-676-1626	1225 E Sunset Dr #110 Bellingham	360-671-5041
	Rite Aid #5236	360-738-4628	1400 Cornwell Ave Bellingham	360-733-1980
	Rite Aid #5238	360-734-6045	220 36 th St Bellingham	360-734-8254
	Rite Aid #5240	360-676-9861	222 Telegraph Rd Bellingham	360-676-8570
	Rite Aid #5237	360-647-2967	3227 Northwest Ave Bellingham	360-647-2175
	Rite Aid #5241	360-332-1336	1733 H St #500 Blaine	360-332-1616
	Rite Aid #6452	360-384-0642	5655 3 rd Ave Ferndale	360-384-1551
	Rite Aid #5242	360-354-4096	8090 Guide Meridian Rd Lynden	360-354-4284
	Fred Meyer #667	360-788-2927	1225 W Bakerview Rd Bellingham	360-788-2933
	Fred Meyer #025	360-738-8033	800 Lakeway Dr Bellingham	360-738-4243

FROM:

Prescribing Provider Contact Information	
Name: _____	Fax: _____
Address: _____	Phone: _____