



FAX PAGE 1 TO THE CONFIDENTIAL FAX LINE: 517.541.2666  
**CONFIDENTIAL CHLAMYDIA & GONORRHEA CASE REPORT FORM**  
**REPORT ALL STIs WITHIN THREE WORKING DAYS.**  
 Questions please call: 269.798.4152 or 517.541.2641

PATIENT INFORMATION					
LAST NAME		FIRST NAME		MIDDLE INITIAL	DOB
ADDRESS		CITY		STATE	ZIP
TELEPHONE		REASON FOR EXAM (CHECK ONE) <input type="checkbox"/> Partner referred patient <input type="checkbox"/> Self-referred <input type="checkbox"/> Screening <input type="checkbox"/> Other _____		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
DATE OF DIAGNOSIS MONTH            DAY            YEAR		DATE OF TREATMENT MONTH            DAY            YEAR		IF FEMALE, PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Arab		RACE (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Gender of Sex Partners <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both <input type="checkbox"/> Unknown	
DIAGNOSIS - DISEASE					
<b>CHLAMYDIA (only one)</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic, uncomplicated <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Other Complications: _____  Date Tested: _____		<b>SITES (all that apply)</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Rectum <input type="checkbox"/> Urine <input type="checkbox"/> Pharynx <input type="checkbox"/> Vagina <input type="checkbox"/> Other: _____		<b>Treatment (all prescribed)</b> <input type="checkbox"/> Azithromycin 1g PO as a single dose <b>OR</b> <input type="checkbox"/> Doxycycline 100mg PO BID for 7 days (preferred for rectal chlamydial infection) <b>Alternatives:</b> <input type="checkbox"/> Erythromycin (base) 500mg PO QID for 7 days <b>OR</b> <input type="checkbox"/> Levofloxacin 500mg PO daily for 7 days <input type="checkbox"/> Other: _____	
<b>GONORRHEA (only one)</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic, uncomplicated <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Disseminated <input type="checkbox"/> Other Complications: _____  Date Tested: _____		<b>SITES (all that apply)</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Rectum <input type="checkbox"/> Urine <input type="checkbox"/> Pharynx <input type="checkbox"/> Vagina <input type="checkbox"/> Other: _____		<b>Treatment (all prescribed)</b> <input type="checkbox"/> Ceftriaxone 250mg IM as a single dose <b>PLUS</b> <input type="checkbox"/> Azithromycin 1g PO as a single dose <b>Alternatives:</b> <input type="checkbox"/> Cefixime 400mg PO as a single dose <b>PLUS</b> <input type="checkbox"/> Azithromycin 1g PO as a single dose <b>For beta-lactam allergic patients:</b> <input type="checkbox"/> Azithromycin 2g PO as a single dose <b>PLUS</b> <input type="checkbox"/> Gentamicin 240mg IM OR Gemifloxacin 320mg PO as a single dose	
<b>Please answer Yes (Y), No (N) or Not Applicable (NA) to the following:</b> <b>DID YOU:</b> _____ Instruct patient to abstain for 7 days after the last dose of antibiotics?                      _____ Instruct pregnant patient to retest in 3-4 wks? _____ Instruct patient to notify all sex partners in the last 60 days to seek treatment?                      _____ Test for pregnancy? _____ Treat all sex partners in last 60 days?                      _____ Advise on pregnancy planning? _____ Advise Condom use?                      _____ Test for other STI's such as Syphilis & HIV? _____ Instruct patient to retest in 90 days?					
<b>Would you like information about Expedited Partner Therapy (EPT)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date			Diagnosing Clinician		
Facility Name			Person Completing Form		
Address			Telephone		
City	State	Zip Code	Email		

**Thank you for reporting an STI. All information will be managed with the strictest of confidentiality.**

#### Expedited Partner Therapy

Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of persons with Chlamydia or Gonorrhea, by providing medicines or prescriptions to the patient. EPT can be offered to heterosexual patients when the provider cannot confidently ensure that all of the patient's sex partners from the prior 60 days will be treated.

#### Legal Authority

Michigan's Communicable Disease rules are propagated under authority conferred by Michigan Implied law 333.5111. Violations of these laws are reported to the State of Michigan. Health professionals are advised to consult with the Health Department or legal counsel if they have questions about their responsibilities under these rules. The Privacy Rule of HIPPA allows for the disclosure of protected health information, without patient consent or authorization, to public health officials who are legally authorized to receive such reports for the purpose of preventing or controlling disease.

#### STI Treatment Guidelines

\*Refer to "STD Diagnostic and Treatment Guidelines" or the Centers for Disease Control and Prevention's (CDC's) website ([www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment)) for further information on treating Chlamydia, Gonorrhea & other sexually transmitted infections.