

CONFIDENTIAL SEXUALLY TRANSMITTED INFECTION CASE REPORT
Report STIs within 3 work days (WAC 246-101-101/301)

PATIENT INFORMATION					
LAST NAME		FIRST NAME		MIDDLE NAME	DATE OF BIRTH MO DAY YR
ADDRESS (<input type="checkbox"/> Unhoused or unstably housed in the past 3 months)			CITY	STATE	ZIP CODE
TELEPHONE ()		EMAIL		ENGLISH SPEAKING? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*instructions on pg. 3</small> Preferred Language (Code*: L ___)	DIAGNOSIS DATE MO DAY YR
SEX ASSIGNED AT BIRTH <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Refused		GENDER IDENTITY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary / Genderqueer <input type="checkbox"/> Transgender MTF <input type="checkbox"/> Transgender FTM <input type="checkbox"/> Other _____ <input type="checkbox"/> Refused		ETHNICITY <input type="checkbox"/> Hispanic or Latina/o/x <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Refused	
				RACE CATEGORY (check all that apply)*: <small>*Instructions on page 3</small> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Refused	
				EXTENDED RACE CODE(S)*: R R R R R	
CURRENTLY PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> NA		REASON FOR EXAM (check one): <input type="checkbox"/> Exposed to Infection <input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam (No Symptoms)		GENDER OF SEX PARTNERS (check all that apply): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary / Genderqueer <input type="checkbox"/> Transgender MTF <input type="checkbox"/> Transgender FTM <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
				HIV STATUS <small>*Submit HIV/AIDS Case Report</small> <input type="checkbox"/> Previous positive <input type="checkbox"/> New HIV diagnosis at this visit* <input type="checkbox"/> Negative HIV test at this visit <input type="checkbox"/> Did not test (unknown status)	
				CURRENTLY ON PrEP? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
DIAGNOSIS - DISEASE					
GONORRHEA (lab confirmed)			SYPHILIS		
DIAGNOSIS (check 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: _____		SITES (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"/> Ocular <input type="checkbox"/> Other: _____		TREATMENT (check all prescribed): <input type="checkbox"/> Ceftriaxone: <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 1 g <input type="checkbox"/> Cefixime: <input type="checkbox"/> 400 mg <input type="checkbox"/> 800 mg <input type="checkbox"/> Azithromycin: <input type="checkbox"/> 1 g <input type="checkbox"/> 2 g <input type="checkbox"/> Doxycycline: <input type="checkbox"/> 100 mg BID x 7 days <input type="checkbox"/> Gentamicin: <input type="checkbox"/> 240 mg <input type="checkbox"/> Gemifloxacin: <input type="checkbox"/> 320 mg <input type="checkbox"/> Other: _____	
Date Tested: _____		Date Prescribed: _____		STAGE (check one): <input type="checkbox"/> Primary (Chancre, etc.) <input type="checkbox"/> Secondary (Rash, etc.) <input type="checkbox"/> Early Latent (< 1 year) <input type="checkbox"/> Unknown Duration or Late <input type="checkbox"/> Congenital	
				MANIFESTATIONS (check all that apply): <input type="checkbox"/> Neurologic <input type="checkbox"/> Otic <input type="checkbox"/> Ocular <input type="checkbox"/> Tertiary	
CHLAMYDIA (lab confirmed)					
DIAGNOSIS (check 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: _____		SITES (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"/> Ocular <input type="checkbox"/> Other: _____		TREATMENT (check all prescribed): <input type="checkbox"/> Azithromycin: <input type="checkbox"/> 1 g <input type="checkbox"/> Doxycycline: <input type="checkbox"/> 100 mg BID x 7 days <input type="checkbox"/> Levofloxacin: <input type="checkbox"/> 500 mg daily x 7 days <input type="checkbox"/> Other: _____	
Date Tested: _____		Date Prescribed: _____		TREATMENT (check one): Bicillin L - A: <input type="checkbox"/> 2.4 MU IM x 1 <input type="checkbox"/> 2.4 MU IM x 3 Doxycycline: <input type="checkbox"/> 100 mg BID x 14 days <input type="checkbox"/> 100 mg BID x 28 days Benzathine <input type="checkbox"/> 50,000 units/kg IM x 1 PCN-G: <input type="checkbox"/> 50,000 units/kg IM x 3 Aqueous <input type="checkbox"/> 18-24 MU/day IV Crystalline for 10-14 days Penicillin G: Other: _____	
				Date Prescribed: _____	
HERPES SIMPLEX			OTHER DISEASES		
DIAGNOSIS <input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal		LABORATORY CONFIRMATION <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Chancroid <input type="checkbox"/> Granuloma Inguinale <input type="checkbox"/> Lymphogranuloma Venereum	
				Date Prescribed: _____	
PARTNER TREATMENT PLAN (check one or more options)					
Providers should manage partner treatment by either treating partners in-person or by prescribing medication for patients to give to their sex partners (see side 2 for additional information).					
<input type="checkbox"/> In-person evaluation - Number of partners treated following medical evaluation: _____			----- Turn over for Partner Treatment Plan Instructions -----		
<input type="checkbox"/> Patient-delivered treatment* - Number of partners for whom provider prescribed or provided expedited partner therapy (EPT) medication pack to be delivered by the patient to their partner(s): _____ *Patient-delivered treatment is not recommended for men who have sex with men or patients with syphilis					
REPORTING CLINIC INFORMATION					
DATE		FACILITY NAME		DIAGNOSING CLINICIAN	
ADDRESS			CITY	STATE	ZIP
PERSON COMPLETING FORM			TELEPHONE ()	EMAIL	

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

PRIVILEGED AND CONFIDENTIAL COMMUNICATIONS: The information contained in this message is privileged, confidential, or otherwise exempt from disclosure and is intended solely for the use of the individual(s) named above. If you are not the intended recipient, you are hereby advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this facsimile in error, please immediately notify the sender by telephone and destroy the original facsimile.

PARTNER MANAGEMENT PLAN INSTRUCTIONS

Gonorrhea or Chlamydia Infection: Partner Treatment

All partners should be treated as if they are infected.

The Washington State Department of Health strongly encourages providers to take responsibility to ensure partner treatment for heterosexuals, by examining and treating all patient's sex partners from the previous 60 days.

If an examination is not possible, providers should offer medication for all sex partners whom patients are able to contact.

Snohomish County Health Department may be able to provide free medication to your patient to give their partner(s), if resources permit. Please contact your local health jurisdiction to report cases and inquire about partner management resources, possibly including EPT medications.

Snohomish County Health Department recommends you refer all **MSM patients** and **all patients with syphilis or newly diagnosed HIV** to the health department for help notifying partners to ensure that partners receive medication; the opportunity to test for HIV, syphilis, gonorrhea, and chlamydia; and evaluation for HIV Pre-Exposure Prophylaxis (PrEP). Please inform the patient that the health department will contact them to assist with partner notification.

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 assure that their partners are treated.

Complete the partner management plan on the Confidential Sexually Transmitted Infection 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 **Snohomish County Health Department at 425.339.5261**.

Other STIs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV, or granuloma inguinale are routinely contacted by public health staff. 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. Per CDC treatment guidelines, sex partners of patients who are diagnosed with early syphilis (primary, secondary, or early latent) and may be incubating disease should be treated regardless of test results. Alternative treatment for penicillin allergy among non-pregnant patients, such as an appropriate dosage of doxycycline, can also be found in the guidelines.

RECOMMENDED REGIMENS FOR ANTIMICROBIALS LISTED ON REPORTS*

GONORRHEA -- Uncomplicated

Ceftriaxone 500 mg IM as a single dose for persons weighing < 150 kg (330 lbs), or 1 g IM as a single dose for persons weighing > 150 kg (330 lbs)[†]

Alternatives for uncomplicated infections of the cervix, urethra, or rectum:[‡]

Gentamicin 240 mg IM as a single dose PLUS azithromycin 2 g PO as a single dose **OR**

Cefixime 800 mg orally as a single dose[†]

[†] If treating with ceftriaxone or cefixime, and chlamydia infection has not been excluded, providers should treat for chlamydia with doxycycline 100 mg PO BID for 7 days. During pregnancy, azithromycin 1 g PO as a single dose is recommended to treat chlamydia.

[‡] Ceftriaxone is the only recommended treatment for pharyngeal gonorrhea. Consult an infectious disease provider or other STI expert for assistance if alternative treatment is required.

CHLAMYDIA -- Uncomplicated

Doxycycline 100 mg PO BID for 7 days **OR**

Azithromycin 1g PO as a single dose

Alternatives:

Erythromycin (base) 500 mg PO QID for 7 days **OR**

Ethylsuccinate 800 mg PO QID for 7 days **OR**

Ofloxacin 300 mg PO BID for 7 days **OR**

Levofloxacin 500 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 -- LATE OR UNKNOWN DURATION

Benzathine penicillin G 2.4 million units IM for 3 doses at 1 week intervals

* Refer to "STD Diagnostic and Treatment Guidelines" or the Centers for Disease Control and Prevention's (CDC's) website (<https://www.cdc.gov/std/treatment/default.htm>) for further information on treating pregnant patients, infections of the pharynx, patients with allergies, treatment of infants, and other details.

DOH 347-102, updated 01.09.2023. For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

List of Preferred Languages:

Instructions: Complete the *Preferred Language* section if the patient's preferred language is **not** English. Patient's preferred language shall be identified by the patient and reported using one of the below categories.

Language Identity Codes:

(L01) Amharic	(L18) Karen	(L35) Sign languages
(L02) Arabic	(L19) Khmer/Cambodian	(L36) Somali
(L03) Balochi/Baluchi	(L20) Kinyarwanda	(L37) Spanish/Castilian
(L04) Burmese	(L21) Korean	(L38) Swahili/Kiswahili
(L05) Cantonese	(L22) Kosraean	(L39) Tagalog
(L06) Chinese (unspecified)	(L23) Lao	(L40) Tamil
(L07) Chamorro	(L24) Mandarin	(L41) Telugu
(L08) Chuukese	(L25) Marshallese	(L42) Thai
(L09) Dari	(L26) Mixteco	(L43) Tigrinya
(L10) Farsi/Persian	(L27) Nepali	(L44) Ukrainian
(L11) Fijian	(L28) Oromo	(L45) Urdu
(L12) Filipino/Pilipino	(L29) Panjabi/Punjabi	(L46) Vietnamese
(L13) French	(L30) Pashto	(L77) Other language
(L14) German	(L31) Portuguese	(L88) Patient declined to respond
(L15) Hindi	(L32) Romanian/Rumanian	(L99) Unknown
(L16) Hmong	(L33) Russian	
(L17) Japanese	(L34) Samoan	

Race Category and Identity Instructions:

Instructions: The patient's race may either be reported in the general *Race Category* section or the *Extended Race* section on page 1 of the case report. When completing the *Extended Race* section, please report using the codes provided in the list below. If the patient self-identifies as more than one race, each race code shall be reported within the *extended race* section. **Unknown** race can be documented within either one of the race sections.

Extended Race Codes:

(R01) Afghan	(R22) Fijian	(R43) Mexican/Mexican American	(R64) Tongan
(R02) Afro-Caribbean	(R23) Filipino	(R44) Middle Eastern	(R65) Ugandan
(R03) Alaska Native	(R24) First Nations	(R45) Mien	(R66) Ukrainian
(R04) American Indian	(R25) Guamanian or Chamorro	(R46) Moroccan	(R67) Vietnamese
(R05) Arab	(R26) Hmong/Mong	(R47) Native Hawaiian	(R68) White
(R06) Asian	(R27) Indigenous-Latina/o/x	(R48) Nepalese	(R69) Yemeni
(R07) Asian Indian	(R28) Indonesian	(R49) North African	(R77) Other race
(R08) Bamar/Burman/Burmese	(R29) Iranian	(R50) Oromo	(R99) Unknown
(R09) Bangladeshi	(R30) Iraqi	(R51) Pacific Islander	
(R10) Bhutanese	(R31) Japanese	(R52) Pakistani	
(R11) Black or African American	(R32) Jordanian	(R53) Puerto Rican	
(R12) Central American	(R33) Karen	(R54) Romanian/Rumanian	
(R13) Cham	(R34) Kenyan	(R55) Russian	
(R14) Chicana/o or Chicanx	(R35) Khmer/Cambodian	(R56) Samoan	
(R15) Chinese	(R36) Korean	(R57) Saudi Arabian	
(R16) Congolese	(R37) Kuwaiti	(R58) Somali	
(R17) Cuban	(R38) Lao	(R59) South African	
(R18) Dominican	(R39) Lebanese	(R60) South American	
(R19) Egyptian	(R40) Malaysian	(R61) Syrian	
(R20) Eritrean	(R41) Marshallese	(R62) Taiwanese	
(R21) Ethiopian	(R42) Mestizo	(R63) Thai	