CHLAMYDIA & GONORRHEA REPORTING FORM

FAX TO **517-541-2666**

REPORT ALL STD/STI WITHIN 3 WORKING DAYS

Communicable Disease Phone: 517-541-2641

PATIENT INFORMATION			
Last Name	**First Name**	**M.I.**	**D.O.B**
Address	**City**	**State**	**Zip**
Telephone	**Reason for Exam (ONLY ONE):** ○ Partner-Referral ○ Self-Referral ○ Screening ○ Other: ______________	**Sex at Birth:** ○ Male ○ Female ○ Other	
Current Gender: ○ Male ○ Female ○ Other ○ Trans to Female ○ Trans to Male	**Gender of Sex Partner:** ○ Male ○ Female ○ Both ○ Other	**If Female, Pregnant:** ○ Yes ○ No	

DIAGNOSIS – DISEASE	
CHLAMYDIA (<u>ONLY ONE</u>): ○ Asymptomatic ○ Symptomatic	**GONORRHEA (<u>ONLY ONE</u>):** ○ Asymptomatic ○ Symptomatic
Source (all that apply): ☐ Urine ☐ Cervix ☐ Rectum ☐ Urethra ☐ Pharynx ☐ Vagina ☐ Other: _______________	**Source (all that apply):** ☐ Urine ☐ Cervix ☐ Rectum ☐ Urethra ☐ Pharynx ☐ Vagina ☐ Other: _______________
Treatment Date (mm/dd/yyyy): ____________________ **Treatment (Check ALL Prescribed):** ☐ Doxycycline 100mg PO 2x/day for 7 days ☐ Azithromycin 1g PO as a single dose ☐ Levofloxacin 500 mg PO daily for 7 days ☐ Amoxicillin 500 mg PO 3x/day for 7 days (pregnant only) ☐ Other: _______________	**Treatment Date (mm/dd/yyyy):** ____________________ **Treatment (Check ALL Prescribed):** ☐ Ceftriaxone 500 mg IM as a single dose ☐ Ceftriaxone 1g IM as a single dose (persons ≥ 300#) ☐ Cefixime 800mg PO as a single dose **CEPHALOSPORIN ALLERGIC PATIENTS:** ☐ Azithromycin 2g PO as a single dose **<u>PLUS</u>** Gentamicin 240mg IM **<u>OR</u>** Gemifloxacin 320mg PO as a single dose ☐ Other: _______________

Check all that apply:

- ☐ Instructed patient to abstain from sexual activity for 7 days
- ☐ Instructed patient to notify all sex partners from the last 60 days to seek treatment
- ☐ Treated all sex partners in last 60 days w/ Expedited Partner Treatment
- ☐ Advised condom use
- ☐ Instructed patient to retest in 90 days; IF PREGNANT, retest in 3 weeks

Ordering Provider: ____

Staff Completing Form: ______________________ **Date:** ____/____/____

Facility Name: ______________________ **Phone: (** ____ **)** ________

Facility Address: ____

<u>Legal Authority</u>: Michigan's Communicable Disease rules are propagated under authority conferred by Michigan implied law 333.5111

Rev. 2021

Barry-Eaton District Health Department

Be Active • Be Safe • Be Healthy