# 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):**<br>○ Partner-Referral ○ Self-Referral<br>○ Screening ○ Other: _____ | **Sex at Birth:**<br>○ Male ○ Female ○ Other | |
| **Current Gender:**<br>○ Male ○ Female ○ Other<br>○ Trans to Female ○ Trans to Male | **Gender of Sex Partner:**<br>○ Male ○ Female ○ Both ○ Other | **If Female, Pregnant:**<br>○ Yes ○ No | |

## DIAGNOSIS – DISEASE

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

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

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Barry-Eaton District Health Department

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