

Chlamydia and Gonorrhea	CONFIDENTIAL CASE REPORT		
INSTRUCTIONS			
<p><i>Please complete all sections of this form utilizing available data and fax completed form to Utah Public Health. As chlamydia and gonorrhea are reportable diseases, client consent to release this information to Utah Public Health is <u>not required</u> and disease reporting is mandatory per Utah State Health Code 26-6-6.</i></p>			
DEMOGRAPHIC INFORMATION			
Last Name:	First Name:	MI:	
Address:	City:	State:	
County:	Zip:	Date of birth: ____/____/____	Age:
Phone #1:	Phone #2:	Phone #3:	
Birth Sex: (Circle one) Male Female	Current Gender: (Circle one) Male Female		
Race: (Check all that apply)			
<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other, specify: _____	
Ethnicity:	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Unknown
Primary Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other, specify: _____
LABORATORY INFORMATION		<i>Please attach a copy of the lab results</i>	
TREATMENT INFORMATION		<i>See CDC STD Treatment Guidelines for complete treatment guidelines including alternate treatment regimens</i>	
Treatment:	<input type="checkbox"/> Azithromycin 1 g orally in a single dose	Treatment Date:	____/____/____
	<input type="checkbox"/> Doxycycline 100 mg orally BID x 7 days		
	<input type="checkbox"/> Other, specify: _____		
Treatment:	<input type="checkbox"/> Ceftriaxone 250 mg IM in a single dose	Treatment Date:	____/____/____
	<input type="checkbox"/> Cefixime 400 mg orally in a single dose		
	<input type="checkbox"/> Other, specify: _____		
REPORTING			
Reporter's name: _____	Phone number: _____		
Reporter's agency: _____	Date reported to public health: ____/____/____		

CLINICAL INFORMATION

Clinician Name: _____ Clinician Phone #: (____) _____ - _____

Pregnant: Yes No Unknown N/A

Date of Last HIV Test: ____/____/____ HIV Status: Pos. Neg. Equivocal Unknown

Is the patient MSM (a man who has sex with men): Yes No Unknown N/A

CONTACT MANAGEMENT

*If known, please complete the following information for
all partners the patient has had sexual contact with in the last 90 days.*

Name: _____ Sex: M F DOB / AGE: _____

Address: _____ Phone: () _____ - _____

Other contact info: _____

Date of last sexual encounter: ____/____/____

Name: _____ Sex: M F DOB / AGE: _____

Address: _____ Phone: () _____ - _____

Other contact info: _____

Date of last sexual encounter: ____/____/____

Name: _____ Sex: M F DOB / AGE: _____

Address: _____ Phone: () _____ - _____

Other contact info: _____

Date of last sexual encounter: ____/____/____