



288 North 1460 West Box #142104 Salt Lake City, UT 84114-2104 (801) 538-6191

Date:

Fax:

To:

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION ON THIS CLIENT:

Because sexually transmitted diseases are reportable to the Health Department, client consent to release this information to the Utah Department of Health is not required per Utah State Health Code 26-6-6.

Name:	DOB:	Age:
Address:	Cell Phone:	
City/State:	Home Phone:	
Zip:		
Race:	Ethnicity: ___Hispanic ___Non-Hispanic	
Sex: ___Male ___Female	Pregnant: ___Yes ___No EDC: _____	
Positive Lab Tests on date: (please attach copy of lab results)		
Tested positive for: *Medication Needed (<i>please fill in what date medication given</i>):		
Chlamydia ___/___/___ Azithromycin 1 gm PO one single dose, OR		
___/___/___ Doxycycline 100 mg PO BID X 7 days		
Gonorrhea** ___/___/___ Ceftriaxone (Rocephin) 250 mg IM one single dose,		
PLUS		
___/___/___ Azithromycin 1 gm PO one single dose		
(**monotherapy no longer recommended for GC regardless of CT result)		
Syphilis Primary, Secondary, early latent ___/___/___ Benzathine penicillin G 2.4 mil units IM		
(administered as one dose)		
Late Latent ___/___/___ Benzathine penicillin G 7.2 mil units total		
(administered as 3 doses of 2.4 mil units IM each at 1 week intervals)		
*See CDC STD treatment guidelines for complete treatment guidelines including alternate treatment for allergies		
Partner Name:	Partner DOB/Age:	
Partner Treated: ___Yes ___No	Medication:	Date Given: ___/___/___
Partner Address:	Partner Phone:	

FAX INFORMATION TO: Bureau of Epidemiology @ Fax: (801) 538-9923.

Office Employee Providing Information _____ (Please print)

Office Phone: (____) _____