



STD MORBIDITY REPORT

Please Complete All Demographic and Medical Information & fax to STD Surveillance at 202-727-4934

HEALTH PROVIDER INFORMATION
REQUEST DATE:
REPORTING FACILITY
TESTING LABORATORY
ATTENDING PHYSICIAN
TELEPHONE
FAX
REPORTING OFFICIAL
HEALTH FACILITY ADDRESS

PATIENT DEMOGRAPHIC INFORMATION
LAST NAME
FIRST NAME
MEDICAL RECORD NUM
DATE OF BIRTH (mo/day/yr)
NUMBER AND STREET ADDRESS
APT. NUM.
CITY
STATE
ZIPCODE
GENDER: Male Female
RACE: White African. Amer. Asian/Pac. Islander Amer. Indian Other/Unknown
MARITAL STATUS: Single Married Separated Divorced Widow(er) Other
ETHNICITY: Hispanic Non-Hispanic Unknown
VISIT COVERAGE: Medicaid Fee Payor/Private Insurance. Other

PATIENT MEDICAL HISTORY
REASON FOR EXAM (Chief Complaint or Type of Visit):
DIAGNOSIS
GONORRHEA
CHLAMYDIA
Risk History: Within Past 90 Days
More Than One Partner
New Partner
Use Condoms with Every Sex Act
CLINICAL PRESENTATIONS
Mucous Cerv. Motion Tender Normal Exam Cervicitis Friability
Lower Abdominal Pain Ectopy Pregnant None of the Above

LABORATORY TEST and TREATMENT INFORMATION - Specify type of screening or diagnostic test
DATE OF TEST
TYPE OF TEST
RESULT
DATE OF TREATMENT
MEDICATION/DRUG
DOSAGE

ADDITIONAL COMMENTS:
Is patient Pregnant? Yes # Wks No
Is patient compliant? Yes No
Was patient offered Chlamydia-expedited partner therapy (EPT)? Yes No
Number of prescriptions of Chlamydia treatment given for partners:

INSTRUCTIONS: PLEASE COMPLETE ALL DEMOGRAPHIC AND MEDICAL INFORMATION. STD reporting requirements are listed in the DC Municipality Regulation, Public Health & Medicine. Upon completion, the information contained in this form must be treated in accordance with federal HIPAA and District confidentiality laws. Please submit reports by facsimile transmission to the STD Information Coordination Team at 202-727-4934. Questions regarding reporting criteria and requirements should be addressed to Surveillance Coordinator at Tel #202-442-4774. DCSTD Form 050102, rev: 2014_01_16