



GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

# STD CASE 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		AGE:
MEDICAL RECORD NUM		DATE OF BIRTH (mo/day/yr)		
NUMBER AND STREET ADDRESS		APT. NUM.	CITY	STATE ZIP CODE
Tel. ( )		Work/Cell. ( )		Emer. Contact: Tel. ( )
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female		RACE: <input type="checkbox"/> White <input type="checkbox"/> African. Amer. <input type="checkbox"/> Asian/Pac. Islander <input type="checkbox"/> Amer. Indian <input type="checkbox"/> Other/Unknown		
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Other		ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		
PATIENT MEDICAL HISTORY				
DATE AND REASON FOR EXAM (Chief Complaint or Type of Visit):				
DIAGNOSIS		<input type="checkbox"/> GONORRHEA <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> HERPES <input type="checkbox"/> SYPHILIS* <input type="checkbox"/> OTHER: _____ *Syphilis Stage: <input type="checkbox"/> Primary (Lesion) <input type="checkbox"/> Secondary (Rash) <input type="checkbox"/> Early Latent (asymptomatic < 1yr) <input type="checkbox"/> Late Latent (asymptomatic > 1yr) <input type="checkbox"/> Late (neurological or other manifestations) <input type="checkbox"/> Congenital <input type="checkbox"/> Other:		
SYMPTOMS (Clinical manifestations, Onset date and Duration)				
LABORATORY TEST and TREATMENT INFORMATION - Specify type of screening or diagnostic test				
DATE OF TEST		TYPE OF LABORATORY TEST		RESULT
DATE OF TREATMENT		MEDICATION/DRUG		DOSAGE
ADDITIONAL COMMENTS:		Is patient Pregnant? ___ Yes ___ # Wks ___ No Is patient compliant? ___ Yes ___ No Was follow up by DOH Partner Services discussed with patient? ___ Yes ___ No Was patient offered Chlamydia-expedited partner therapy (EPT)? ___ Yes ___ No Number of prescriptions for Chlamydia treatment given for partners: _____		
<b>INSTRUCTIONS: PLEASE COMPLETE ALL DEMOGRAPHIC AND MEDICAL INFORMATION.</b> 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				