THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
HAHSTA NOTIFIABLE DISEASE REPORT FORM

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH

HEALTH PROVIDER INFORMATION

Reset Form

Reporting Facility Name: | Date Form Completed: / / | Person Completing Form: | Phone: ( ) -

Program: CTR: ☐ SBSP: ☐ YSSP: ☐ N/A: ☐

Street Address: | City: | County/Ward: / | State/Country: / | ZIP Code:

PATIENT IDENTIFIERS AND DEMOGRAPHICS

Last Name: | First Name: | Date of Birth: / / | Social Security Number: - - | Medical Record Number:

Address Type (select one): ☐Residential ☐Correctional Facility ☐Foster Home ☐Homeless ☐Postal ☐Shelter ☐Temporary ☐Bad/Invalid Address

Current Street Address: | Apt #: | Phone: ( ) -

City: | County/Ward: / | State/Country: / | ZIP Code:

Sex assigned at birth:
☐Male ☐Female

If female, **pregnant**?
☐Yes ☐No
If yes, weeks: _____

Gender identity:
☐Male ☐Female
☐Transgender Female
☐Transgender Male
☐Other: _____

Ethnicity:
☐Hispanic/Latino
☐Not Hispanic/Latino
☐Unknown

Race (select all that apply):
☐American Indian/Alaskan Native
☐Asian ☐Black/African American
☐Native Hawaiian/Pacific Islander
☐White ☐Unknown

Was the patient notified that they may be contacted by DOH Disease Intervention Specialists (DIS)?
☐Yes ☐No

PATIENT HISTORY

Date of Exam: / /

Reason for Exam (chief complaint or type of visit):

Gender of patient's sex partner(s): ☐Male ☐Female ☐Both

Injection Drug Use: ☐Yes ☐No ☐Unk

Is/was the patient on PrEP: ☐Yes ☐No

DIAGNOSIS AND TREATMENT (Include lab results when sending case report forms)

CHLAMYDIA

Positive specimen site (select all that apply):
☐Genital ☐Urine ☐Rectum
☐Pharynx ☐Other: _____

Date treated: / /
Treatment: ☐Azithromycin 1g ☐Azithromycin 2g ☐Doxycycline 100mg BID x7 days
☐Other: _____

Was the patient offered Chlamydia-**expedited partner therapy** (EPT)? ☐Yes ☐No ——— If yes, number of prescriptions/meds provided: _____

GONORRHEA

Positive specimen site (select all that apply):
☐Genital ☐Urine ☐Rectum
☐Pharynx ☐Other: _____

Date treated: / /
Treatment: ☐Ceftriaxone 250mg IM ☐Azithromycin 1g ☐Cefixime 400mg PO
☐Azithromycin 2g ☐Doxycycline 100mg BID x7 days ☐Gentamicin 240mg IM
☐Gemifloxacin 320mg PO ☐Other: _____

Was the patient offered Gonorrhea-**expedited partner therapy** (EPT)? ☐Yes ☐No ——— If yes, number of prescriptions/meds provided: _____

HEPATITIS B (select all that were positive/reactive)

☐HBsAg ☐HBsAb
☐HBcAb, Total ☐HBcAb, IgM

Date Diagnosed: / / **Diagnosis type**: ☐Past ☐Current **Vaccinated?** ☐
Describe **symptoms**, if any: _____

HEPATITIS C

(select all that were positive/reactive)
☐HCV Ab ☐HCV RNA

Date Diagnosed: / / **Diagnosis type**: ☐Past ☐Current **Treated?** ☐
Describe **symptoms**, if any: _____

HIV (check all that were positive/reactive)

☐HIV Rapid Test ☐HIV-1/2 Ag/Ab
☐HIV-1/2 type differentiating
☐HIV-1 WB ☐HIV RNA or NAT
Diagnosis documented by a physician?
☐Yes ☐No

Date Diagnosed: / /
Was client informed of HIV status? ☐Yes ☐No ☐Unknown
Was client linked to HIV medical care? ☐Yes ☐No ☐Unknown
If Yes, where linked? _____ ☐Check if SAME as Reporting Facility
Did you verify client attended appointment for HIV care? ☐Yes ☐No ☐Unknown

SYPHILIS

☐Primary (chancre)
☐Secondary (rash, etc.)
☐Early Latent (<1 yr.)
☐Late Latent (>1 yr.)
☐Unknown duration
☐Congenital

With manifestation of:
☐Neurologic
☐Ocular
☐Otic

Date of last RPR: / / **Result**: ☐Pos ☐Neg ☐Unk **Quant. RPR**: 1: ____
Date treated:
Treatment: ☐Bicillin 2.4mu IM x1 ☐Bicillin 2.4mu IM x3 wks ☐Other: _____
☐Doxycycline 100mg po bid x14 days ☐Doxycycline 100mg po bid x28 days
Describe any **symptoms**: _____
If neurosyphilis, **CSF-VDRL Date**: **CSF-VDRL Titer Results**: _____

OTHER

☐Herpes 1 ☐Herpes 2 ☐Lymphogranuloma venereum

Form Rev. 4/2017

COMMENTS

Reset Form

Please complete and submit reports by facsimile to the STD Information Coordination Team at 202-727-4934 within 48 hours of diagnosis or suspected infection. You may also contact a HAHSTA Disease Investigator to retrieve documents. Questions regarding reporting of HIV, viral hepatitis, sexually transmitted infections please dial 202-671-4916.