



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

**HEALTH PROVIDER INFORMATION**

<b>Reporting Facility Name:</b>	<b>Date Form Completed:</b> / /	<b>Person Completing Form:</b>	<b>Phone:</b>
<b>Street Address:</b>	<b>City:</b>	<b>County/Ward:</b> /	<b>State/Country:</b> / <b>ZIP Code:</b>

**PATIENT DEMOGRAPHICS**

<b>Last Name:</b>	<b>First Name:</b>	<b>Date of Birth:</b> / /	<b>Social Security Number:</b> - -	<b>Medical Record Number:</b>
<b>Address Type:</b> <input type="checkbox"/> Residential <input type="checkbox"/> Bad Address <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary				
<b>Current Street Address:</b>		<b>Apt. Number:</b>	<b>Phone:</b>	
<b>City:</b>	<b>County/*Ward:</b> /	<b>State/Country:</b> /	<b>ZIP Code:</b>	
<b>Emergency Contact:</b>		<b>Emergency Contact Telephone:</b>		
<b>Sex at birth:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female If female, pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, weeks:	<b>Gender Identity:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Unknown	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	<b>Race:</b> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	Was the patient notified that they will be contacted by DOH Partner Services? <input type="checkbox"/> No <input type="checkbox"/> Yes Is the patient on PrEP? <input type="checkbox"/> No <input type="checkbox"/> Yes

**PATIENT MEDICAL INFORMATION/HISTORY**

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

**DIAGNOSIS (Include lab results when sending case report forms)**

**CHLAMYDIA**

<b>Sites (select all that apply):</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input type="checkbox"/> Vagina <input type="checkbox"/> Other:	<b>Date Treated:</b> / / <b>Treatment:</b> <input type="checkbox"/> Azithromycin 1g <input type="checkbox"/> Azithromycin 2g <input type="checkbox"/> Doxycycline 100mg BIDx7 <input type="checkbox"/> Other: <b>How many medications/prescriptions was the patient given for their partners?</b> or <input type="checkbox"/> Not Offered
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**GONORRHEA**

<b>Sites (select all that apply):</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input type="checkbox"/> Vagina <input type="checkbox"/> Other:	<b>Date Treated:</b> / / <b>Treatment:</b> <input type="checkbox"/> Ceftriaxone 250mg IM <input type="checkbox"/> Azithromycin 1g <input type="checkbox"/> Cefixime 400 mg PO <input type="checkbox"/> Azithromycin 2g <input type="checkbox"/> Doxycycline 100mg BIDx7 <input type="checkbox"/> Gentamicin 240mg IM <input type="checkbox"/> Gemifloxacin 320mg PO <input type="checkbox"/> Other: <b>How many medications/prescriptions was the patient given for their partners?</b> or <input type="checkbox"/> Not Offered
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**HEPATITIS B**

<input type="checkbox"/> Surface Antigen (HBsAg) <input type="checkbox"/> Surface antibody (anti-HBs)	<b>Date Diagnosed:</b> / / <b>Diagnosis Type:</b> <input type="checkbox"/> Past <input type="checkbox"/> Current <b>Treatment:</b> <input type="checkbox"/> Describe Symptoms, If Noted:
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**HEPATITIS C**

<input type="checkbox"/> Anti HCV Screening Test <input type="checkbox"/> Anti HCV RIBA <input type="checkbox"/> Anti HCV RNA	<b>Date Diagnosed:</b> / / <b>Diagnosis Type:</b> <input type="checkbox"/> Past <input type="checkbox"/> Current <b>Treatment:</b> <input type="checkbox"/> Describe Symptoms, If Noted:
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**HIV**

<input type="checkbox"/> HIV- 1/2 Ag/Ab <input type="checkbox"/> HIV-1/2 Differentiating (e.g., Multispot) <input type="checkbox"/> HIV-1 WB <b>Diagnosis documented by a physician?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Date Diagnosed:</b> / / <b>Was client informed of HIV status?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Was client linked to HIV medical care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Linked, where?</b> <input type="checkbox"/> Check if SAME as Reporting <b>If not, Why?</b> <input type="checkbox"/> Already in HIV care <input type="checkbox"/> Declined HIV care
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**SYPHILIS**

<input type="checkbox"/> Primary (chancre) <input type="checkbox"/> Secondary (rash, etc.) <input type="checkbox"/> Early Latent (<1 year duration but no symptoms) <input type="checkbox"/> Late Latent (>1 year duration but no symptoms) <input type="checkbox"/> Unknown duration <input type="checkbox"/> Congenital Neurosyphilis: <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Date Treated:</b> / / <b>Treatment:</b> <input type="checkbox"/> Bicillin 2.4mu IMx1 <input type="checkbox"/> Bicillin 2.4mu IMx3wks <input type="checkbox"/> Other: <b>Date of Last RPR:</b> / / <b>Result:</b> <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk <b>Quant. RPR:</b> Describe Symptoms, If Noted: <b>If Neurosyphilis, CSF-VDRL Date:</b> / / <b>CSF-VDRL Titer Result:</b>
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**OTHER**

Herpes 1  Herpes 2  Lymphogranuloma Venereum

**COMMENTS**

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