

**EXAMPLES OF STD-RELATED DATA COLLECTION FORMS**



# MINNESOTA CONFIDENTIAL STD CASE REPORT

Health care providers should use this form to report LAB CONFIRMED cases of sexually transmitted disease as mandated by state law (Minnesota Rules 4605.7040). These diseases are of such major public health concern that surveillance of their occurrence is in the public interest. All case reports are classified as private under the Minnesota Government Data Practices Act (§13.38). Your cooperation in reporting is both encouraged and appreciated.

Laboratory reports do not substitute for physician case reports. Coexisting infections (such as gonorrhea and chlamydia) may be reported on a single form. Do not use this form to report cases of HIV infection. Contact the STD and HIV Section at (651) 201-5414 if you have questions about HIV case reporting.

**INSTRUCTIONS:** Print CAPITAL LETTERS clearly within the boxes with a black or blue pen. Do not touch the sides of the boxes. Do not use labels on this form. For circles, either completely fill them in or mark with an "X" or "✓". Do not submit photocopies of this form.

**For additional information or consultation, contact:**

Minnesota Department of Health  
Infectious Disease Epidemiology, Prevention and Control Division  
STD and HIV Section  
P.O. Box 64975  
St. Paul, Minnesota 55164-0975  
Telephone: (651) 201-5414  
TTY: (651) 201-5797



**SAMPLE:** 1 2 3 4 AND ● X ✓

**Please indicate if you would like to receive:**

- Additional case report forms
- MDH return envelopes
- STD Treatment Guidelines\*
- STD Surveillance Data Summary\*\*
- Partner Services Unit information/brochure\*\*
- STD Reporting Frequently Asked Questions (HIPPA)\*\*\*

**Materials needed by:** \_\_\_\_\_  
(date)

- \* STD Treatment Guidelines are available at: [www.cdc.gov/std/treatment/default.htm](http://www.cdc.gov/std/treatment/default.htm)
- \*\* Available at: [www.health.state.mn.us/divs/idepc/dtopics/stds/index.html](http://www.health.state.mn.us/divs/idepc/dtopics/stds/index.html)
- \*\*\* Available at: [www.health.state.mn.us/divs/idepc/dtopics/reportable/index.html](http://www.health.state.mn.us/divs/idepc/dtopics/reportable/index.html)

## IMPORTANT INFORMATION:

Treatment of sexual partners is essential to prevent reinfection and further transmission. All sexual partners who had contact with the patient during the following time periods should be preventively treated, even if the partner's diagnostic tests are negative:

- Chlamydia - 60 days before onset
- Gonorrhea - 60 days before onset
- Syphilis - within 90 days of last exposure to patient

## PARTNER SERVICES DATA FOR UNTREATED PARTNERS

Please provide name(s) and locating information for UNTREATED PARTNERS if you would like MDH assistance with partner notification. This information is private and no information that could identify your patient will be revealed to partners.

In most cases, partner follow-up cannot be initiated unless specific locating information is given below. If partners are not followed up with appropriate treatment, reinfection of the patient may occur.

PARTNER'S NAME

ADDRESS

CITY/STATE/ZIP

PHONE NUMBER

RACE/ETHNICITY AGE DATE OF BIRTH SEX

APPROX DATE OF LAST EXPOSURE

PHYSICAL DESCRIPTION ADDITIONAL INFORMATION

PARTNER'S NAME

ADDRESS

CITY/STATE/ZIP

PHONE NUMBER

RACE/ETHNICITY AGE DATE OF BIRTH SEX

APPROX DATE OF LAST EXPOSURE

PHYSICAL DESCRIPTION ADDITIONAL INFORMATION

# CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT

## PATIENT DATA

LAST NAME		FIRST NAME		INITIAL	
ADDRESS		TELEPHONE		REASON FOR EXAM: (CHECK ONE)	
CITY/TOWN		STATE		<input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam—No Symptoms <input type="checkbox"/> Exposed to Infection	
DATE OF DIAGNOSIS	ETHNICITY	RACE - Check all that apply	SEX	DATE OF BIRTH	GENDER OF SEX PARTNERS
MO DAY YR	H Non-His U	W B AI ANI A NH OBI O U	M F		M F Both U

## DIAGNOSIS-DISEASE

Instructions

PARTNER MANAGEMENT PLAN

▼ Select method of ensuring partner treatment

**1.**  Health Department to assume responsibility for partner treatment.

**HEALTH DEPARTMENT ASSISTANCE ONLY RECOMMENDED IF:**

- Patient has had 2 or more sex partners in the last 60 days, **or**
- Patient does not think he/she will have sex again with sex partners from the last 60 days, **or**
- Patient is unable or unwilling to contact one or more partner, **or**
- Patient is a man who has sex with other men.

**2.**  Provider will ensure all partners treated (**FREE medications available**).

Indicate number to be treated ( \_\_\_\_\_ )

**3.**  All partners have been treated.

Indicate number treated ( \_\_\_\_\_ )

<p style="text-align: center; font-weight: bold;">GONORRHEA (lab confirmed)</p> <p>DIAGNOSIS - ▼ only one</p> <p><input type="checkbox"/> Asymptomatic</p> <p><input type="checkbox"/> Symptomatic - Uncomplicated</p> <p><input type="checkbox"/> Pelvic Inflammatory Disease</p> <p><input type="checkbox"/> Ophthalmia</p> <p><input type="checkbox"/> Other Complications:</p> <p>DATE TESTED _____</p>	<p style="text-align: center; font-weight: bold;">SYPHILIS</p> <p>TREATMENT - ▼ all given/presc.</p> <p><input type="checkbox"/> Cepodoxime</p> <p><input type="checkbox"/> Doxycycline</p> <p><input type="checkbox"/> Levofloxacin*</p> <p><input type="checkbox"/> Cefixime</p> <p><input type="checkbox"/> Other</p> <p>Other, specify _____</p> <p>*Quinolones not recommended as first choice for GC treatment; see treatment guidelines.</p> <p>DATE RX _____</p>
<p style="text-align: center; font-weight: bold;">CHLAMYDIA TRACHOMATIS (lab confirmed)</p> <p>DIAGNOSIS - ▼ only one</p> <p><input type="checkbox"/> Asymptomatic</p> <p><input type="checkbox"/> Symptomatic - Uncomplicated</p> <p><input type="checkbox"/> Pelvic Inflammatory Disease</p> <p><input type="checkbox"/> Ophthalmia</p> <p><input type="checkbox"/> Other Complications:</p> <p>DATE TESTED _____</p>	<p style="text-align: center; font-weight: bold;">SYPHILIS</p> <p>TREATMENT - ▼ all given/presc.</p> <p><input type="checkbox"/> Azithromycin</p> <p><input type="checkbox"/> Doxycycline</p> <p><input type="checkbox"/> Erythromycin</p> <p><input type="checkbox"/> Ofloxacin</p> <p><input type="checkbox"/> Levofloxacin</p> <p><input type="checkbox"/> Other</p>

<p>DIAGNOSING CLINICIAN</p> <p>FACILITY NAME</p> <p>CITY</p>	<p>PERSON COMPLETING REPORT</p> <p>ADDRESS</p> <p>STATE</p> <p>TELEPHONE</p>
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Need Additional Case Report Forms

DOH 347-102 (Rev. 8/2006)

STATE OFFICE COPY

# FLORIDA DEPARTMENT OF HEALTH – PRACTITIONER DISEASE REPORT FORM

(Please complete the following information to report the suspect or diagnosis of a disease which is reportable under Florida Administrative Code 64D-3.)

DH2136,10/06

**Patient Information:**

Last Name	Area Code + Phone Number	<input type="checkbox"/> Please check here if you would like more copies of the form
First Name	MI	Date of Birth (MMDDYYYY)
Address	State	Social Security Number (no dashes)
City	Zip Code	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown

**Disease Specific Information:**

Date of Onset:       Disease Fatal?  Yes  No

Patient Hospitalized?  Yes  No Discharge Date:

Hospital Name: \_\_\_\_\_

Medicaid Number or Insurance: \_\_\_\_\_

Pregnancy Status:  Not Pregnant  Pregnant

Number of Months: \_\_\_\_\_

Race:  White  Black  Asian  American Indian/Alaska Native  Native Hawaiian/Pacific Islander  Other: \_\_\_\_\_

**Disease or Condition Reporting: For HIV/AIDS and HIV exposed newborns please report per forms indicated in F.A.C. 64D-3.**

**Report immediately upon:**

**! = Initial suspicion 24/7 by phone**

**☎ = Diagnosis 24/7 by phone**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anthrax <b>☎ !</b>                               | <input type="checkbox"/> Enteric disease due to <i>Escherichia coli</i> O157:H7 <b>☎ !</b>                              | <input type="checkbox"/> Severe acute respiratory syndrome (SARS) <b>☎ !</b>                                     |
| <input type="checkbox"/> Botulism, foodborne <b>☎ !</b>                   | <input type="checkbox"/> Enteric disease due to other pathogenic <i>Escherichia coli</i> <b>☎ !</b>                     | <input type="checkbox"/> Shigellosis   |
| <input type="checkbox"/> Botulism, infant                                 | <input type="checkbox"/> Giardiasis (acute)   | <input type="checkbox"/> Smallpox <b>☎ !</b>   |
| <input type="checkbox"/> Botulism, other/wound/unspecified <b>☎ !</b>     | <input type="checkbox"/> Glanders <b>☎ !</b>  | <input type="checkbox"/> <i>Staphylococcus aureus</i> , intermediate or full resistance to vancomycin <b>☎ !</b> |
| <input type="checkbox"/> Brucellosis <b>☎ !</b>                           | <input type="checkbox"/> Gonorrhea  | <input type="checkbox"/> <i>Staphylococcus enterotoxin B</i> <b>☎ !</b>  |
| <input type="checkbox"/> California serogroup virus disease               | <input type="checkbox"/> Granuloma inguinale  | <input type="checkbox"/> Streptococcal disease, invasive Group A   |
| <input type="checkbox"/> Campylobacteriosis                               | <input type="checkbox"/> <i>Haemophilus influenzae</i> , meningitis and invasive disease <b>☎ !</b>                     | <input type="checkbox"/> <i>Streptococcal pneumoniae</i> , invasive disease                                      |
| <input type="checkbox"/> Chancroid  | <input type="checkbox"/> Hansen's disease   | <input type="checkbox"/> Syphilis  |
| <input type="checkbox"/> Chlamydia  | <input type="checkbox"/> Hantavirus infection <b>☎ !</b>  | <input type="checkbox"/> Syphilis, pregnancy or neonate <b>☎ !</b>   |
| <input type="checkbox"/> Cholera <b>☎ !</b>                               | <input type="checkbox"/> Hemolytic uremic syndrome <b>☎ !</b>   | <input type="checkbox"/> Tetanus   |
| <input type="checkbox"/> Ciguatera fish poisoning                         | <input type="checkbox"/> Hepatitis, acute A <b>☎ !</b>  | <input type="checkbox"/> Toxoplasmosis, acute  |
| <input type="checkbox"/> <i>Clostridium perfringens</i> epsilon toxin     | <input type="checkbox"/> Hepatitis, acute B, C, D, E, G   | <input type="checkbox"/> Trichinellosis (Trichinosis)  |
| <input type="checkbox"/> Conjunctivitis, in neonatal ≤14 days             | <input type="checkbox"/> Hepatitis, chronic B, C  | <input type="checkbox"/> Tuberculosis (TB)   |
| <input type="checkbox"/> Creutzfeldt-Jakob disease (CJD)                  | <input type="checkbox"/> Hepatitis B surface antigen positive in pregnant woman or child up to 24 months                | <input type="checkbox"/> Tularemia <b>☎ !</b>  |
| <input type="checkbox"/> Cryptosporidiosis                                | <input type="checkbox"/> Herpes simplex virus (HSV) in infants up to six months   | <input type="checkbox"/> Typhoid fever <b>☎ !</b>  |
| <input type="checkbox"/> Cyclosporiasis                                   | <input type="checkbox"/> HSV anogenital in children ≤12 yrs   | <input type="checkbox"/> Typhus fever, endemic   |
| <input type="checkbox"/> Dengue   | <input type="checkbox"/> Human papilloma virus (HPV) anogenital in children ≤12 yrs                                     | <input type="checkbox"/> Typhus fever, epidemic <b>☎ !</b>   |
| <input type="checkbox"/> Diphtheria <b>☎ !</b>                            | <input type="checkbox"/> HPV associated laryngeal papillomas or recurrent respiratory papillomatosis in children ≤6 yrs | <input type="checkbox"/> Vaccinia disease <b>☎ !</b>   |
| <input type="checkbox"/> Eastern equine encephalitis virus disease        | <input type="checkbox"/> HPV cancer associated strains  | <input type="checkbox"/> Varicella (chickenpox)  |
| <input type="checkbox"/> Ehrlichiosis, human granulocytic (HEG)           | <input type="checkbox"/> Influenza – due to novel or pandemic strains <b>☎ !</b>  | <input type="checkbox"/> Date of vaccination _/ _/ _   |
| <input type="checkbox"/> Ehrlichiosis, human monocytic (HME)              | <input type="checkbox"/> Influenza – associated pediatric mortality in persons <18 yrs <b>☎ !</b>                       | <input type="checkbox"/> Varicella mortality   |
| <input type="checkbox"/> Ehrlichiosis, human other or unspecified species | <input type="checkbox"/> Lead poisoning   | <input type="checkbox"/> Venezuelan equine encephalitis virus disease <b>☎ !</b>                                 |
| <input type="checkbox"/> Encephalitis, other (non-arboviral)              |   | <input type="checkbox"/> Vibriosis, <i>Vibrio</i> infections   |
|   |   | <input type="checkbox"/> Viral hemorrhagic fevers <b>☎ !</b>   |
|   |   | <input type="checkbox"/> West Nile virus disease   |
|   |   | <input type="checkbox"/> Western equine encephalitis virus disease   |
|   |   | <input type="checkbox"/> Yellow fever <b>☎ !</b>   |
- Any Outbreak, grouping, or clustering of patients having similar disease, symptoms, syndromes: **☎ !** \_\_\_\_\_

**Provider Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Provider Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

**Medical Information:**

Diagnosis Date:

Test Conducted?  Yes  No Please attach lab record (if available)

Lab Name: \_\_\_\_\_

Lab Test Date:       Lab Results: \_\_\_\_\_

Treatment Provided?  Yes  No Test Method: \_\_\_\_\_

Treatment: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_



# LOS ANGELES COUNTY STD PROGRAM CHLAMYDIA & GONORRHEA LABORATORY REPORT



DATE OF REPORT  -  -

REPORT BY

**1 PATIENT'S LAST NAME**  **FIRST NAME**  **M.I.**

**CITY/TOWN**  **STATE**  **ZIP CODE**

**AREA CODE**  **DAY TELEPHONE NUMBER**  -

**AREA CODE**  **EVENING TELEPHONE NUMBER**  -

**Birth Date**  -  -  **AGE:**

**GENDER:**  
 Male  
 Female  
 Transgender (M to F)  
 Transgender (F to M)  
 Unknown or Refused

**PREGNANT:**  
 Yes  Unknown  
 No

**POSTPARTUM:**  
 Yes  Unknown  
 No

**RACE (X all that apply):**  
 White  
 Black or African American  
 Native American or Alaska Native  
 Asian or Asian American  
 Native Hawaiian or Pacific Islander  
 Unknown  Refused  
 Other:

**2 DOCTOR'S LAST NAME**  **DOCTOR'S FIRST NAME**  **M.I.**

**FACILITY/CLINIC NAME**

**FACILITY STREET ADDRESS**  **SUITE/UNIT NO.**

**CITY/TOWN**  **STATE**  **ZIP CODE**

**AREA CODE**  **TELEPHONE NUMBER**  -  **AREA CODE**  **FAX NUMBER**  -

**For HIV REPORTING:**  
 Call (213) 351-8516 or visit  
[www.lapublichealth.org/hiv](http://www.lapublichealth.org/hiv)

**3 LABORATORY'S NAME**

**LABORATORY'S STREET ADDRESS**

**CITY/TOWN**  **STATE**  **ZIP CODE**

**AREA CODE**  **TELEPHONE NUMBER**  -  **AREA CODE**  **FAX NUMBER**  -

**4 CHLAMYDIA**

**TEST NAME**

**TEST RESULT**

**SPECIMEN TYPE**

**SPECIMEN SITE:**  
 Urine  Vaginal  Other   
 Cervix  Rectum  
 Urethra  Nasopharynx

**Spec. Coll. Date (MM-DD-YY):**  -  -

**Test Date (MM-DD-YY):**  -  -

**Specimen ID #:**

**COMMENTS:**

**GONORRHEA**

**TEST NAME**

**TEST RESULT**

**SPECIMEN TYPE**

**SPECIMEN SITE:**  
 Urine  Vaginal  Other   
 Cervix  Rectum  
 Urethra  Nasopharynx

**Spec. Coll. Date (MM-DD-YY):**  -  -

**Test Date (MM-DD-YY):**  -  -

**Specimen ID #:**

**COMMENTS:**



RISK FACTORS		
I. Sexual Behaviors	Within past 3 months	Within past 12 months
<p><i>Sex is defined as having engaged in oral, anal or vaginal contact with partners.</i></p> <p>Y - Yes   N - No   R - Refused to Answer   D - Did not Ask</p>		
<p><b>Has the patient:</b></p> <p>1. Had sex with a male?</p>	<p>Y/N/R/D</p> <input type="text"/>	<p>Y/N/R/D</p> <input type="text"/>
<p>2. Had sex with a female?</p>	<input type="text"/>	<input type="text"/>
<p>3. Had sex with an anonymous partner?</p>	<input type="text"/>	<input type="text"/>
<p>4. Had sex with a person known to him/her to be an IDU?</p>	<input type="text"/>	<input type="text"/>
<p>5. Had sex while intoxicated and/or high on drugs?</p>	<input type="text"/>	<input type="text"/>
<p>6. Exchanged drugs/money for sex?</p>	<input type="text"/>	<input type="text"/>
<p>7. <b>[Females only]</b> Had sex with a person who is known to her to be an MSM?</p>	<input type="text"/>	<input type="text"/>
II. Drug Use Behaviors	Within past 3 months	Within past 12 months
<p>Y - Yes   N - No   R - Refused to Answer   D - Did not Ask</p>		
<p>8. Engaged in injection drug use?</p>	<p>Y/N/R/D</p> <input type="text"/>	<p>Y/N/R/D</p> <input type="text"/>
<p>9. During the past 12 months, which of the following injection or non-injection drugs have been used?</p>		<p> <input type="checkbox"/> Crack                      <input type="checkbox"/> Methamphetamines  <input type="checkbox"/> Cocaine                    <input type="checkbox"/> Nitrates/Poppers  <input type="checkbox"/> Heroin                        <input type="checkbox"/> Erectile dysfunction medications (e.g., Viagra)  <input type="checkbox"/> None                           <input type="checkbox"/> Other, specify: _____            _____            _____         </p>
III. Other Risk Factors	Within past 3 months	Within past 12 months
<p>Y - Yes   N - No   R - Refused to Answer   D - Did not Ask</p>		
<p>10. Been incarcerated?</p>	<p>Y/N/R/D</p> <input type="text"/>	<p>Y/N/R/D</p> <input type="text"/>

STD Testing						
Date Collected	Provider	Test	Specimen Source	Qualitative Result	Quantitative Result	
___/___/___	_____	_____	<input type="text"/>	P N I U Q C	1: _____	
___/___/___	_____	_____	<input type="text"/>	P N I U Q C	1: _____	
___/___/___	_____	_____	<input type="text"/>	P N I U Q C	1: _____	
___/___/___	_____	_____	<input type="text"/>	P N I U Q C	1: _____	

HIV Testing						
Tested for HIV at this event?			Previously Tested for HIV?			
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R <input type="checkbox"/> Not Asked			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R <input type="checkbox"/> Not Asked			
Date Collected	Provider	Test	Specimen Source	Qualitative Result	Provider Confirmed	
___/___/___	_____	_____	<input type="text"/>	P N I U Q C	<input type="text"/>	
___/___/___	_____	_____	<input type="text"/>	P N I U Q C	<input type="text"/>	
___/___/___	_____	_____	<input type="text"/>	P N I U Q C	<input type="text"/>	

Signs and Symptoms					
Signs/Symptoms	Earliest Observation Date	Anatomic Site	Clinician Observed?	Patient Described?	Duration (Days)
1. <input type="text"/>	___/___/___	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
2. <input type="text"/>	___/___/___	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
3. <input type="text"/>	___/___/___	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
If Other, Please Describe: _____					

STD History			
Previous STD History? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R			
Condition	Dx Date (mm/yyyy)	Rx Date (mm/yyyy)	Confirmed?
1. <input type="text"/>	___/___/___	___/___/___	<input type="text"/>
2. <input type="text"/>	___/___/___	___/___/___	<input type="text"/>
3. <input type="text"/>	___/___/___	___/___/___	<input type="text"/>

STD/HIV Treatment/Counseling		
Treatment Date	Provider	Drug and Dosage
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____

Treatment Comments: \_\_\_\_\_

Incidental Antibiotic Treatment in Last 12 Months?  Y  N  U

Rx Date (mm/yyyy)	Drug/Dosage/Duration	Condition
___/___/___	_____	_____
___/___/___	_____	_____

Anti-Retroviral Therapy for Diagnosed HIV Infection? In Last 12 Months?  Y  N  U  R Ever?  Y  N  U  R

HIV Pre-Test Counseled at this event?  Y  N  U  R HIV Post-Test Counseled at this event?  Y  N  U  R




Marginal Partners									
	Name	Sex	Age	Race	Height	Weight	Hair	Exposure	Locating Information
1									
2									
3									
4									
5									

**Interview / Investigation Comments**

DRRAFT

**Travel History and Internet Use**



Interview Record Codes				
Disease/Diagnosis Codes	Institution Types	Y/N/U/R	Time	
<b>030</b> - HepB acute w/o delta <b>031</b> - HepB acute w/ delta <b>033</b> - HepB chronic w/o delta <b>034</b> - HepB chronic w/ delta <b>042</b> - Hepatitis delta <b>051</b> - Hepatitis C, acute <b>053</b> - Hepatitis E <b>054</b> - Hepatitis C, chronic <b>070</b> - Hepatitis, unknown <b>100</b> - Chancroid <b>200</b> - Chlamydia <b>300</b> - Gonorrhea (uncomplicated) <b>350</b> - Resistant Gonorrhea <b>400</b> - Non-Gonococcal Urethritis (NGU) <b>450</b> - Mucopurulent Cervicitis (MPC) <b>490</b> - PID Syndrome <b>500</b> - Granuloma Inguinale <b>600</b> - Lymphogranuloma Venereum (LGV) <b>710</b> - Syphilis, primary <b>720</b> - Syphilis, secondary <b>730</b> - Syphilis, early latent <b>740</b> - Syphilis, unknown duration <b>745</b> - Syphilis, late latent <b>750</b> - Syphilis, late w/ symptoms <b>800</b> - Genital Warts <b>850</b> - Herpes <b>900</b> - HIV Infection <b>950</b> - AIDS (Syndrome)	<b>G</b> - Group Home <b>J</b> - Jail <b>O</b> - Other <b>P</b> - Prison <b>Q</b> - Mental Health Center <b>R</b> - Rehabilitation Center <b>X</b> - Drug Treatment/Detox Center <b>Y</b> - Juvenile Detention	<b>Y</b> - Yes <b>N</b> - No <b>U/UN</b> - Unknown <b>R</b> - Refused to Answer	<b>W</b> - Weeks <b>M</b> - Months <b>Y</b> - Years	
	<b>Marital Status</b>		<b>Method of Case Detection</b>	
	<b>S</b> - Single, Never Married <b>M</b> - Married <b>SEP</b> - Separated <b>D</b> - Divorced <b>W</b> - Widowed <b>C</b> - Cohabitation <b>U</b> - Unknown <b>R</b> - Refused to Answer	<b>20</b> - Screening <b>21</b> - Self-Referral (symptomatic patients seeking testing) <b>22</b> - Patient Referred Partner <b>23</b> - Health Department Referred Partner <b>24</b> - Cluster Related (Social Contact (Suspect) or Associate) <b>88</b> - Other		
	<b>Hispanic/Latino</b>		<b>Reasons Not Interviewed:</b>	<b>Place of Interview</b>
	<b>Y</b> - Yes, Hispanic/Latino <b>N</b> - No, not Hispanic/Latino <b>U</b> - Unknown <b>R</b> - Refused to Answer	<b>U</b> - Unable to locate <b>P</b> - Physician Refusal <b>R</b> - Refused to Answer <b>D</b> - Deceased <b>L</b> - Language Barrier <b>O</b> - Other	<b>C</b> - Clinic <b>F</b> - Field <b>T</b> - Telephone <b>I</b> - Internet <b>O</b> - Other	
	<b>Race</b>		<b>Imported Case</b>	
	<b>A/AN</b> - American Indian or Alaskan Native <b>A</b> - Asian <b>B</b> - Black or African American <b>NH/PI</b> - Native Hawaiian or Other Pacific Islander <b>W</b> - White <b>U</b> - Unknown <b>R</b> - Refused to Answer	<b>N</b> - Not an imported case <b>C</b> - Yes, imported from another <u>country</u> <b>S</b> - Yes, imported from another <u>state</u> <b>J</b> - Yes, imported from another <u>county/jurisdiction</u> in the state <b>D</b> - Yes, imported but not able to determine source county, state, and/or country <b>U</b> - Unknown		
	<b>Pregnancy Outcome</b>		<b>Specimen Source</b>	<b>Anatomic Site</b>
	<b>D</b> - Live Birth <b>S</b> - Stillborn <b>M</b> - Miscarriage <b>A</b> - Abortion <b>U</b> - Unknown	<b>01</b> - Cervix/Endocervix <b>02</b> - Lesion - Genital <b>03</b> - Lesion - Extra Genital <b>04</b> - Lymph Node Aspirate <b>05</b> - Oropharynx <b>06</b> - Ophthalmia/Conjunctiva <b>07</b> - Other <b>08</b> - Other Aspirate <b>09</b> - Rectum <b>10</b> - Urethra <b>11</b> - Urine <b>12</b> - Vagina <b>13</b> - Blood/Serum <b>14</b> - Cerebrospinal Fluid (CSF) <b>88</b> - Not Applicable <b>99</b> - Unknown	<b>A</b> - Anus/Rectum <b>B</b> - Penis <b>C</b> - Scrotum <b>D</b> - Vagina <b>E</b> - Cervix <b>F</b> - Naso-Pharynx <b>G</b> - Mouth/Oral Cavity <b>H</b> - Eye-Conjunctiva <b>I</b> - Head <b>J</b> - Torso <b>K</b> - Extremities (Arms, Legs, Feet, Hands) <b>N</b> - Not Applicable (N/A) <b>O</b> - Other <b>U</b> - Unknown	
	<b>Type of Facility</b>		<b>Qualitative Lab Result</b>	
<b>01</b> - HIV Counseling/Testing Site <b>02</b> - STD Clinic <b>03</b> - Drug Treatment <b>04</b> - Family Planning <b>05</b> - RETIRED (Not to be used) <b>06</b> - TB Clinic <b>07</b> - Other HD Clinic <b>08</b> - Private MD/HMO <b>09</b> - RETIRED (Not to be used) <b>10</b> - Hospital (ER) <b>11</b> - Correctional facility <b>12</b> - Lab <b>13</b> - Blood Bank <b>14</b> - Labor and Delivery <b>15</b> - Prenatal <b>16</b> - Job Corps <b>17</b> - School-based Clinic <b>18</b> - Mental Health Services <b>29</b> - Hospital (Other) <b>66</b> - Indian Health Services <b>77</b> - Military <b>88</b> - Other <b>99</b> - Unknown	<b>P</b> - Positive <b>N</b> - Negative <b>I</b> - Indeterminate/Equivocal <b>UN</b> - Unknown/ No Result <b>Q</b> - Quantity Not Sufficient <b>C</b> - Contaminated specimen			
<b>Residence Type</b>		<b>Places met or had sex with partners</b>		
<b>A</b> - Apartment <b>B</b> - Mobile Home <b>C</b> - Migrant Camp <b>D</b> - Dorm <b>G</b> - Group Home <b>H</b> - House/Condo <b>J</b> - Jail <b>M</b> - Hotel/Motel <b>N</b> - Homeless <b>O</b> - Other <b>P</b> - Prison <b>Q</b> - Mental Health Center <b>R</b> - Rehabilitation Center <b>U</b> - Unknown <b>X</b> - Drug Treatment/Detox Center <b>Y</b> - Juvenile Detention	<b>A</b> - Adult Book Store/Cinema <b>B</b> - Bars <b>C</b> - Cruising in Automobile <b>D</b> - Dance Halls <b>E</b> - Escort Services <b>F</b> - Baths/Spas/Resorts <b>G</b> - Place of Worship <b>H</b> - Home <b>I</b> - Chat Rooms/Lines/Email/Internet <b>J</b> - Jail/Prison <b>K</b> - Clubs <b>L</b> - Beach	<b>M</b> - Motel/Hotel <b>N</b> - Shopping Mall <b>O</b> - Other <b>P</b> - Project/Shelter <b>Q</b> - School <b>R</b> - Gyms/Health Clubs <b>S</b> - Partner's Home <b>T</b> - Street <b>U</b> - Circuit Party <b>V</b> - Cruise (Boat) <b>W</b> - Work <b>X</b> - Park/Rest Area		
<b>Neurological Involvement</b>				
<b>C</b> - Yes, Confirmed <b>P</b> - Yes, Probable <b>N</b> - No <b>U</b> - Unknown				
<b>Gender/Sex:</b>				
<b>M</b> - Male <b>F</b> - Female <b>MTF</b> - Male to Female Transsexual <b>FTM</b> - Female to Male Transsexual <b>T</b> - Transgender <b>U</b> - Unknown <b>R</b> - Refused to Answer				

Interview Record Codes		
Signs/Symptoms	STD History	
<b>A</b> - Discharge or MPC <b>B</b> - Chancre, Sores, Lesions, or Ulcers <b>C</b> - Rash <b>D</b> - Dysuria <b>E</b> - Itching <b>F</b> - Alopecia (Hair loss) <b>G</b> - Condylomata Lata <b>H</b> - Bleeding <b>I</b> - Pharyngitis (Sore Throat) <b>J</b> - Painful Sex <b>K</b> - Abdominal Pain <b>L</b> - Swelling/Inflammation <b>M</b> - Mucous Patch <b>N</b> - Lymphadenopathy <b>O</b> - Other <b>P</b> - Balanitis <b>Q</b> - Fever <b>R</b> - Cervical Friability <b>S</b> - Ectopy <b>T</b> - Epididymitis <b>V</b> - Proctitis <b>W</b> - Adnexal tenderness/Cervical motion tenderness	<b>Y</b> - Yes, patient has a history of STD <b>N</b> - No, patient has never had a prior STD <b>U</b> - Unknown if patient has had a prior STD <b>R</b> - Patient refused to answer any questions regarding prior STD History	
	<b>Interview Type</b>	
	<b>O</b> - <i>Original Interview</i> the initial interview with an infected patient. <b>R</b> - <i>Re-Interview</i> any interview after the Original Interview of an infected patient. <b>C</b> - <i>Cluster Interview</i> any interview of a partner or cluster regarding the index case. <b>U</b> - <i>Unable to interview</i> (may include situations where the original patient was not interviewed, but sex partners and/or clusters were initiated from other activities).	
	<b>Referral</b>	
<b>1</b> - <u>Patient (Client)</u> : No health department involvement in the referral of this partner/cluster. <b>2</b> - <u>Provider</u> : DIS or other health department staff were involved in the referral of this partner/cluster . <b>3</b> - <u>Dual (contract)</u> : A combination of provider and patient effort to bring contact/cluster to services.		
<b>Source/Spread</b>		
<b>SO</b> - The source of infection for the original patient <b>SP</b> - A spread from the original patient. <b>U</b> - Partner infection is <u>not related to the original patient</u> . <b>UN</b> (Unknown) - It is unknown whether a partner infection is related to the original patient.		
<b>Partner/Cluster</b>		
<b>PARTNER</b> - Persons having sexual activities (of any type) or sharing needles with the original patient. <b>P1</b> - Sex Partner <b>P2</b> - Needle sharing Partner <b>P3</b> - Both Sex and Needle sharing Partner <b>SOCIAL CONTACT (Suspect)</b> - Persons named by an infected person (e.g., the original patient or an infected partner or cluster). <b>S1</b> - Person who has or had symptoms suggestive of the Condition(s) documented. <b>S2</b> - Person who is named as a sex partner of a known infected person. <b>S3</b> - Any other person who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk). <b>ASSOCIATE</b> - Persons named by an uninfected partner or cluster. <b>A1</b> - Person who has or had symptoms suggestive of the Condition(s) documented. <b>A2</b> - Person who is named as a sex partner of a known infected person. <b>A3</b> - Any other person who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk).		
<b>Dispositions</b>		
<b>STD Dispositions</b>	<b>HIV Dispositions</b>	
<b>A</b> - Preventative Treatment <b>B</b> - Refused Preventative Treatment <b>C</b> - Infected, Brought to Treatment <b>D</b> - Infected, Not Treated <b>E</b> - Previously Treated for This Infection <b>F</b> - Not Infected <b>G</b> - Insufficient Information to Begin Investigation <b>H</b> - Unable to Locate <b>J</b> - Located, Refused Examination and/or Treatment <b>K</b> - Out Of Jurisdiction <b>L</b> - Other	<b>1</b> - Previous Positive <b>2</b> - Previous Negative, New Positive <b>3</b> - Previous Negative, Still Negative <b>4</b> - Previous Negative, Not Re-tested <b>5</b> - Not Previously Tested, New Positive <b>6</b> - Not Previously Tested, New Negative <b>7</b> - Not Previously Tested, Not Tested Now <b>G</b> - Insufficient Information to Begin Investigation <b>H</b> - Unable to Locate <b>J</b> - Located, Refused Counseling and/or Testing <b>K</b> - Out Of Jurisdiction <b>L</b> - Other	



**HIV Testing**

Tested for HIV at this event?  Y  N  U  R  Not Asked      Previously Tested for HIV?  Y  N  U  R  Not Asked

Date Collected:  /  /       Provider:       Test:       Specimen Source:       Qualitative Result:  P  N  I  U  Q  C      Provider Confirmed:

**Signs and Symptoms**

**STD History**

**Interview Period Partners**

Signs/Symptoms:       Earliest Observation Date:  /  /       Anatomic Site:       Duration (Days):

1.       /      /            \_\_\_\_\_

2.       /      /            \_\_\_\_\_

3.       /      /            \_\_\_\_\_

If Other, Please Describe: \_\_\_\_\_

Previous STD History?  Y  N  U  R

Condition      Dx Date (mm/yyyy)      Rx Date (mm/yyyy)

1.  /  /       /      /

2.  /  /       /      /

3.  /  /       /      /

Female:  /  /       Unknown:  U      Refused:  R      1

Male:  /  /       Unknown:  U      Refused:  R

Female:  /  /       Unknown:  U      Refused:  R      2

Male:  /  /       Unknown:  U      Refused:  R

**Partner/Cluster Information**

1      Last Name:       First Name:       AKA:       Jurisdiction:

P/CL:       First Exposure:  /  /       Freq.:       Last Exposure:  /  /       Sex:  M  F  T  U  R      Pregnant:  Y  N  U  R      Spouse:  Y  N  U  R

Condition 1	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Ix Type	Referral <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	FR#	Dispo	<input type="text"/> / <input type="text"/> / <input type="text"/>	Cond.	<input type="text"/>
	Ix Date	Init. Date	Ix DIS #					Dispo Date		DIS #
Condition 2	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Ix Type	Referral <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	FR#	Dispo	<input type="text"/> / <input type="text"/> / <input type="text"/>	Cond.	<input type="text"/>
	Ix Date	Init. Date	Ix DIS #					Dispo Date		DIS #

2      Last Name:       First Name:       AKA:       Jurisdiction:

P/CL:       First Exposure:  /  /       Freq.:       Last Exposure:  /  /       Sex:  M  F  T  U  R      Pregnant:  Y  N  U  R      Spouse:  Y  N  U  R

Condition 1	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Ix Type	Referral <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	FR#	Dispo	<input type="text"/> / <input type="text"/> / <input type="text"/>	Cond.	<input type="text"/>
	Ix Date	Init. Date	Ix DIS #					Dispo Date		DIS #
Condition 2	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Ix Type	Referral <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	FR#	Dispo	<input type="text"/> / <input type="text"/> / <input type="text"/>	Cond.	<input type="text"/>
	Ix Date	Init. Date	Ix DIS #					Dispo Date		DIS #

3      Last Name:       First Name:       AKA:       Jurisdiction:

P/CL:       First Exposure:  /  /       Freq.:       Last Exposure:  /  /       Sex:  M  F  T  U  R      Pregnant:  Y  N  U  R      Spouse:  Y  N  U  R

Condition 1	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Ix Type	Referral <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	FR#	Dispo	<input type="text"/> / <input type="text"/> / <input type="text"/>	Cond.	<input type="text"/>
	Ix Date	Init. Date	Ix DIS #					Dispo Date		DIS #
Condition 2	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	Ix Type	Referral <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	FR#	Dispo	<input type="text"/> / <input type="text"/> / <input type="text"/>	Cond.	<input type="text"/>
	Ix Date	Init. Date	Ix DIS #					Dispo Date		DIS #

**Social History**

**Interview, Internet, and Investigation Comments**

Places Met Partners      Places Had Sex

Type      Name      Type      Name

\_\_\_\_\_       \_\_\_\_\_

\_\_\_\_\_       \_\_\_\_\_

\_\_\_\_\_       \_\_\_\_\_

Did not ask       Did not ask

Refused to answer       Refused to answer

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Incidental Antibiotic Treatment in Last 12 Months?  Y  N  U

Rx Date (mm/yyyy)      Drug/Dosage/Duration      Condition

/  /       \_\_\_\_\_      \_\_\_\_\_

/  /       \_\_\_\_\_      \_\_\_\_\_

### Integrated Partner Services Interview Record

Chart # \_\_\_\_\_ Case # \_\_\_\_\_ Date Assigned \_\_\_/\_\_\_/\_\_\_ **G** 0003195

Employee ID: \_\_\_\_\_ County: \_\_\_\_\_ **GC**  **CT**   $\Sigma$   Stage \_\_\_\_\_ Neuro? \_\_\_\_\_

**Patient Locating Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ AKA \_\_\_\_\_ E-mail \_\_\_\_\_ ChatID \_\_\_\_\_ Home Phone# \_\_\_\_\_

Residence Street \_\_\_\_\_ Apt. Number \_\_\_\_\_ Cell Phone# \_\_\_\_\_ WorkPlace \_\_\_\_\_ Work Phone# \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ School \_\_\_\_\_ Hours at Home \_\_\_\_\_ Hours at Work \_\_\_\_\_

Date initial lab report: \_\_\_/\_\_\_/\_\_\_ Lab Name \_\_\_\_\_ Lot # \_\_\_\_\_ Conf. Lab \_\_\_/\_\_\_/\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ RPR/VDRL \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Notes: \_\_\_\_\_ TPPA \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Referral Basis:**

+ Lab test  Ptx referred partner  Provider Case Report

Health Dept. referral  Cluster  OOJ

Most Recent Negative Test \_\_\_/\_\_\_/\_\_\_

Previous Dx?  Y  N  U When? \_\_\_/\_\_\_/\_\_\_  
1 0 99

Previous Titer \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Exposure Period Instructions:** Chlamydia or gonorrhea: = 60 Days (prior to testing)  
 Syphilis: \*Primary Syphilis = 4 months + 1 week (127 days); Secondary Syphilis = 8 months (237 days); Other/late Syphilis = 1 year

**Exposure/Interview Period:** month \_\_\_ day \_\_\_ Year \_\_\_ to month \_\_\_ day \_\_\_ Year \_\_\_

Interview Date \_\_\_/\_\_\_/\_\_\_ Eng. Speaking:  Y  N Lang? \_\_\_\_\_  
1 0

Sex:  M  F  TGMF  TGRM Interview Method:  1 In person  2 Phone Location:  1 Field  2 Clinic  3 LHJ

1) What is your date of birth? \_\_\_/\_\_\_/\_\_\_ Age? \_\_\_\_\_

2) Are you of Hispanic or Latino/a origin?  Y  N  U  R  
1 0 99 88

3) What is your racial Background? (check all that apply)  W  B  AI/AN  A  NH/OPI  Oth \_\_\_\_\_  U  R

4) What is the main reason you went for an exam when you were diagnosed with an STD? (Check one)

<input type="checkbox"/> 1 Pap smear/pelvic exam	<input type="checkbox"/> 5 Annual physical exam	<input type="checkbox"/> 10 Rescreening
<input type="checkbox"/> 2 Pregnancy Test/Prenatal Care	<input type="checkbox"/> 6 Wanted a routine STD exam	<input type="checkbox"/> 11 Partner was Dx with STD
<input type="checkbox"/> 3 Family Planning/Birth Control	<input type="checkbox"/> 7 Wanted symptoms checked out	<input type="checkbox"/> 99 Unknown
<input type="checkbox"/> 4 Abortion	<input type="checkbox"/> 8 Not examined/contact to STD	<input type="checkbox"/> 13 Other _____
	<input type="checkbox"/> 9 Outreach screening/referral	<input type="checkbox"/> 88 Refused

5) Have you had any of the following symptoms in the past 60 days? (read all, check all that apply)

<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Pain when you urinate/pee _____(days)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Pain in pelvis/abdomen _____(days)
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Anal/rectal pain, bleeding _____(days)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Abnormal, non-menstrual bleeding _____(days)
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Abnormal disch. penis/vagina _____(days)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Other _____(days)

6) Have you been to an STD clinic in the last year, not including this visit?  Y  N  U  R  
1 0 99 88

7) Were you diagnosed with Pelvic Inflammatory Disease at your visit on \_\_\_/\_\_\_/\_\_\_?  Y  N  U  R  
1 0 99 88

8) At the time of this STD diagnosis, were you pregnant?(if No, skip to #9)  Y  N  U  R (If pregnant) Are you getting prenatal care?  Y  N  U  R  
1 0 99 88

Patient Name:

Case Number:

9) What is your current employment/job status? 1  FT 2  PT 3  Unemployed <1 Year 4  Unemployed >1 Year 5  Retired 6  Disabled 88  R

10) Are you a student? Full or part-time? 1  N 2  FT 3  PT 88  R

11) What is the highest level of school that you have completed? 1  < HS grad 2  HS/GED 3  Some College Tech/AA Degree 4  Coll Grad+ 88  R

12) Have you been in jail or prison for more than 24 hours in the last 3 months? 1  Y 0  N 99  U 88  R

13) Have you had sex with someone in the last 3 months who had been in jail or prison in the last 3 months? 1  Y 0  N 99  U 88  R

14) What was your housing situation in last 3 months?  
1  Permanent/stable 2  Non-permanent/Unstable 3  Institutionalized 4  Other \_\_\_\_\_ 88  R

15) Have you already taken medicine for chlamydia, gonorrhea or syphilis? (If NO go to 17) 1  Y 0  N 99  U 88  R

16) Did you take all of your medicine for gonorrhea, chlamydia or syphilis?  
1  Y 0  N 99  U 88  R 3  Still taking meds.

17) Before being told you had an STD this time, has a doctor or other medical provider ever told you that you had (read all):  
Gonorrhea? 1  Y 0  N 99  U 88  R When last? \_\_\_\_/\_\_\_\_(mo/yr) Chlamydia? 1  Y 0  N 99  U 88  R When last? \_\_\_\_/\_\_\_\_(mo/yr)  
Syphilis? 1  Y 0  N 99  U 88  R When last? \_\_\_\_/\_\_\_\_(mo/yr) Herpes? 1  Y 0  N 99  U 88  R When last? \_\_\_\_/\_\_\_\_(mo/yr)

18) In the LAST YEAR have you had sex with men, women or both? Sex includes vaginal, anal or oral sex.  
1  Men (go to # 19) 2  Women (go to #22) 3  Both men & women 88  Refused

19) How many MEN have you had sex with in the LAST YEAR? Sex includes vaginal, anal or oral sex. (For both MSM & WSM)  
\_\_\_\_\_ 999  Don't know/not sure 888  Refused

20) How many MEN have you had ANAL sex with in the LAST YEAR? (For MSM only)  
\_\_\_\_\_ 999  Don't know/not sure 888  Refused

21) How many MEN have you had vaginal, anal or oral sex with since \_\_\_\_\_ (start of exposure period) but before being treated?  
\_\_\_\_\_ 999  Don't know/not sure 888  Refused

22) How many WOMEN have you had vaginal, anal or oral sex with in the LAST YEAR?  
\_\_\_\_\_ 999  Don't know/not sure 888  Refused

23) How many WOMEN have you had vaginal, anal or oral sex with since \_\_\_\_\_ (start of exposure period) but before being treated?  
\_\_\_\_\_ 999  Don't know/not sure 888  Refused

24) Syphilis interview period partners: # of Males # of Females  
Known Sex Partners Interview Period \_\_\_\_\_ 99  U 88  R Interview Period \_\_\_\_\_ 99  U 88  R  
Anon. Sex Partners Interview Period \_\_\_\_\_ 99  U 88  R Interview Period \_\_\_\_\_ 99  U 88  R

25) Have you ever given anyone money or drugs for sex? 1  Y 0  N 88  R Last Time? \_\_\_\_/\_\_\_\_(mo/yr)

26) Have you ever gotten money or drugs from anyone for sex? 1  Y 0  N 88  R Last Time? \_\_\_\_/\_\_\_\_(mo/yr)

27) In the past year, where have you met your sex partners? (Mark all and then ask "Anywhere else?")  
 Bars/Clubs  Rave/Commercial Party  Friend/Relative's/Private Party  With Part. >1 Yr.  
 Church  School/College Campus  Adult Bookstore  Refuses All  
 Public Park/Rest Stop  Adult Movie Theater  Mall/Shopping Cntr/Store/Public Area  
 Bath House/Sex Club  Internet/On-line Chat  Other/Unk \_\_\_\_\_

28) Have you EVER met a sex partners through the Internet?

1 0 88
Y N R

Last Time (mo/yr) Site, Chat Board, Etc:

29) In the past year have you met any of your sex partners at (read and check all that apply):

88 Refused all venue info

1 0 88
Y N R

Bath House/ Sex Club (describe) Last Time (mo/yr)

1 0 88
Y N R

Circuit Party (describe) Last Time (mo/yr)

30) In the past year, have you used (read and check all that apply, probe for other):

1 0 88
Y N R

Crack Last Time (mo/yr)

1 0 88
Y N R

Nitrates/Poppers

Last Time (mo/yr)

Y N R

Meth Last Time (mo/yr)

Y N R

Viagra/Cialis/Lavitra

Last Time (mo/yr)

Y N R

Heroin Last Time (mo/yr)

Y N R

Cocaine

Last Time (mo/yr)

Y N R

Any IDU Last Time (mo/yr)

Y N R

Any Needle Share

Last Time (mo/yr)

Y N R

Other Last Time (mo/yr)

88 Refused all drug information

31) Have you traveled out of town since (interview period start until being treated) and had sex with anyone there?

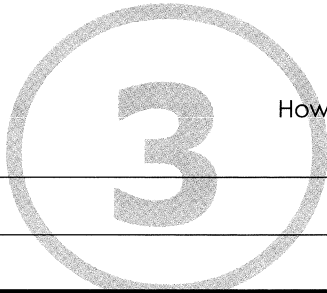
This excludes persons who traveled there with you, such as your current partner, but may include people you already knew who lived there.

Y N U R
1 0 99 88

Place?

When?

How many people did you have sex with there?



32) Have you ever had an HIV test? Y N U R

Are you HIV positive? Y N U R

Date of 1st Positive? / / Date of 1st positive unknown
Date of Last Negative? / / Date of last negative unknown

If HIV Positive:

Do you have an HIV Primary Care Provider? Y N U R

Who is your provider?

Ever taken antiretrovirals? Y N U R

Referred to EIP/HIV Services

Taken antiretrovirals in last 30 days? Y N U R

33) Did you get an HIV test when you got tested for this STD? Y N U R

(For STD Clinic Patients)

Reason if refused HIV testing Collection Date / /

Results: EIA HIV Rapid HIV WB HIV RNA P N Ind. Unk.

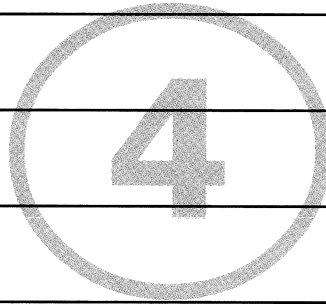
34) Final OP Interview Status: 1 Complete 2 Refused 3 Partial 4 Not Located
5 Re-interview 6 Language Barrier 7 >30 days 8 O.O.J. 9 Prov. Refused

Local Use: A B C D E F G H I J K L

**35) Contact Attempts**(please document attempts, methods and outcomes)

- A) Date \_\_\_/\_\_\_/\_\_\_ <sup>1</sup>Phone <sup>2</sup>Field <sup>3</sup>Letter <sup>4</sup>E-mail Outcome: \_\_\_\_\_
- B) Date \_\_\_/\_\_\_/\_\_\_ <sup>1</sup>Phone <sup>2</sup>Field <sup>3</sup>Letter <sup>4</sup>E-mail Outcome: \_\_\_\_\_
- C) Date \_\_\_/\_\_\_/\_\_\_ <sup>1</sup>Phone <sup>2</sup>Field <sup>3</sup>Letter <sup>4</sup>E-mail Outcome: \_\_\_\_\_
- D) Date \_\_\_/\_\_\_/\_\_\_ <sup>1</sup>Phone <sup>2</sup>Field <sup>3</sup>Letter <sup>4</sup>E-mail Outcome: \_\_\_\_\_

36) Date Case Closed:                      Date \_\_\_/\_\_\_/\_\_\_



**Field Record#** 0604804 **G** **Index Patient Case ID** (Original Patient Case#)

**Partner Type:**  Sex  Cluster  Unk/Ind. **Source or Spread?**  So  Sp  Indeterminate (for syph. contacts)

**Partner Locating Information:**  OP Doesn't Know  Anon.  OP Refuses

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ AKA \_\_\_\_\_ E-mail \_\_\_\_\_ Chat ID \_\_\_\_\_ Home Phone# \_\_\_\_\_  
 Residence Street \_\_\_\_\_ Apt. Number \_\_\_\_\_ Cell Phone# \_\_\_\_\_ WorkPlace \_\_\_\_\_ Work Phone# \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ School \_\_\_\_\_ Hours at home \_\_\_\_\_ Hours at Work \_\_\_\_\_

1) What is this person's sex?  M  F  TGMF  TGRM **1a) If female, is this person pregnant?**  Y  N  U  R

2) What is this person's date of birth? \_\_\_\_/\_\_\_\_/\_\_\_\_  U  R **Age?** (if date of birth unknown)

3) Is this person of Hispanic or Latino/a origin?  Y  N  U  R

4) What is this person's racial background? (check all that apply)  W  B  AI/AN  A  NH/OPI  Oth  U  R

5) Does this person speak English?  Y  N  U  R **If not, what language does he/she speak?** \_\_\_\_\_

6) When was the FIRST time you had oral, anal or vaginal sex with this person? \_\_\_\_/\_\_\_\_/\_\_\_\_

7) When was the LAST time you had oral, anal or vaginal sex with this person? \_\_\_\_/\_\_\_\_/\_\_\_\_

8) How many times have you have sex with this person since \_\_\_\_ (interview period start)?  0  1  2-5  6-10  >10  Ref

9) Do you live with this person?  Y  N  U  R

10) Where did you first meet this person?  Work/Place of Employment  Refused all venue info  
 Bars/Clubs  Rave/Commercial Party  Friend's House/Private Party  Church  
 School/College Campus  Adult Bookstore  Public Park/Rest Stop  Adult Movie Theater  
 Mall/Shopping Center  Bath House/Sex Club  Internet/On-line Chat  Other/Unk \_\_\_\_\_

11) Since (interview period start) \_\_\_\_\_, have you (had) \_\_\_\_\_ with this person?(read and check all that apply)  
 Given oral sex  Gotten oral sex  Refused all sex risks  
 Vaginal sex with a condom  Vaginal without a condom  No sex with this partner in int. period  
 Anal insertive with a condom  Anal insertive without a condom **(If no sex in interview period, skip to 13)**  
 Anal receptive with a condom  Anal receptive without a condom

12) Since (interview period start) \_\_\_\_\_, has this person.....?(read and check all that apply)  Refused all risk info  
 Y  N  U  R Given money/drugs for sex  Y  N  U  R Been pregnant (Female Partners)  
 Y  N  U  R Gotten money/drugs for sex  Y  N  U  R Did either of you use viagra/cialis or levitra?

13) What is this person's HIV status?  1 Pos  0 Negative  99 Unknown  88 Refused

14) Does partner already know they might have CT, GC or syphilis?  Y  N  U  R **If YES, go to 15 if NO skip to 16**

15) If yes, how did they find out?  1 I notified this partner  2 Other SP notified partner  3 Provider Dx  99  U  88  R

16) Did this person tell you that they had already been treated?  Y  N  U  R

17) Do you think this person has already been treated?  Y  N  U  R **If YES, go to 18 if NO skip to 19**

18) How did - or how do you think - that this person got treated(check all - ask if the meds were a public health partner pack)?  
 1 Saw provider for Dx & Tx  2 OP gave meds to this partner  3 OP gave prescription to partner  
 4 Saw provider/ no STD but Tx  5 Saw provider with OP and got Tx  6 OP doesn't know how partner got treated  
 7 Got PH 'partner pack'  8 Other \_\_\_\_\_ (note: Tx=treatment)

19) Did you have sex without a condom with them after finishing your meds but before they got or finished theirs?  Y  N  U  R

20) Are you able to contact this person again?  Y  N  U  R **if no, skip to 22**

21) Will you have sex with this partner again?  Y  N  U  R

22) Partner management plan (select only one):  
 1 Previously tx'd  2 Patient initiated contact  3 DIS initiated contact (go to #24)  4 Insufficient info (go to dispo)  88 Refuses

23) Patient initiated management method (select only one):  
 1 Delivered meds via pharmacy PU  2 Refuses meds but will notify partner  3 Delivered meds via onsite stock  
 4 Refused meds & patient refuses to notify  5 Delivered meds via mail  6 Refuses meds no other information

24) DIS initiated management method (select only one):  
 1 Contacted, meds called in for PU at pharmacy  2 Contacted, examined (not confirmed, includes those contacted and referred)  
 3 Contacted, meds delivered from onsite stock  4 Contacted, treated in Jail/Other Facility  
 5 Contacted, meds mailed  6 Contacted refuses all exam/treatment methods  
 7 Contacted, examined (confirmed)  8 Not Contacted - Give reason:

*Initial Disposition* - These responses reflect whether this partner has been notified, evaluated and treated at the time of the first interview with the index case (original patient).

Partner Referral Type:  Patient  DIS Date Completed: / /

Has this partner already been notified?  Y  N  U Has this partner already been evaluated by a clinician?  Y  N  U

Has this partner already been tested for any of the following STDs and what was the result?

Gonorrhea:  Tested Positive  Tested Negative  Tested, Unknown Result  Not Tested  Unknown if Tested

Chlamydia:  Tested Positive  Tested Negative  Tested, Unknown Result  Not Tested  Unknown if Tested

Syphilis:  Tested Positive  Tested Negative  Tested, Unknown Result  Not Tested  Unknown if Tested

Has this partner been treated for all STDs? Yes, ALL  Yes, SOME   N  U

Did this patient get medications or a prescription for this partner or did this partner receive medications without seeing a clinician? If so, from whom did the patient or partner receive the medication?

PDPT from Diagnosing Physician  PDPT from DIS or health dept. staff  PDPT given by different index patient  No PDPT

Did index patient already give this partner PDPT?  Yes  No  No PDPT/EPT provided to index patient  Unknown

Did the health department verify that this partner was treated?

Yes, talked to partner  Yes, talked to provider or saw medical record  No  Unknown

HIV Disposition Codes: Date completed / /

What type of partner referral was used to notify this partner?

Patient referral (index patient notified and referred for testing)  DIS Referral  No Referral  Unknown

Has this partner already been notified that they may have been exposed to HIV?  Y  N  U  OP not known to be HIV Pos.

Has this partner already been seen by a medical provider for an HIV test?  Y  N  U

What was this partner's HIV status prior to being tested for this exposure?  Pos  Neg  Unknown (includes never tested)

Has this partner been tested since being notified of exposure to this index case?  Yes  No  Unknown

What was the result of that test?  Pos  Neg  Unknown  Not tested  Previously known positive

Was test result verified by the health department through direct communication with the partner, provider or medical record?

Yes, talked to partner  Yes, talked to provider or saw medical record  No  Unknown

*Final Disposition* - These responses reflect whether this partner has been notified, evaluated and treated at the time that public health closes the case.

Partner Referral Type:  Patient  DIS Date Completed: / /

Has this partner already been notified?  Y  N  U Has this partner already been evaluated by a clinician?  Y  N  U

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Chlamydia:  Tested Positive  Tested Negative  Tested, Unknown Result  Not Tested  Unknown if Tested

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Initial Disposition

Final Disposition

**Chlamydia/Gonorrhea Test  
Region X Infertility Prevention Project**

Client Name GREY AREAS: LAB USE ONLY

Lab Number Date Received

**CT/GC Test**  
 1  Probe    4  Cell Cult.    7  PCR  
 8  SDA    10  SA    11  TC-TMA

Client Number Clinician

--	--

Date of Birth Client Zip Code

1 9	
-----	--

Date Specimen Collected Specimen Site

2 0	
-----	--

Service Site Client Sex

Cervix     Urethra    1  F  
 Urine     Rectal    2  M  
 Vaginal-patient  
 Vaginal-clinician  
 Other \_\_\_\_\_

**Test Results**  
 1  Unsatisfactory Specimen  
 2  Negative CT    5  Negative GC  
 3  Positive CT    6  Positive GC  
 4  Equivocal CT    7  Equivocal GC

Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date Reported By

**PROVIDER/CLINIC ADDRESS:**

Medicaid No. \_\_\_\_\_

ICD Code \_\_\_\_\_

Spokane Regional Health District Laboratory  
1101 W College Ave., Room 210, Spokane, WA 99201

<p><b>ETHNICITY:</b>                  1 <input type="checkbox"/> Hispanic                  2 <input type="checkbox"/> Non-Hisp.</p>	<p><b>RACE:</b> (check all that apply)                  1 <input type="checkbox"/> White                  2 <input type="checkbox"/> Black                  3 <input type="checkbox"/> Amer. Ind./AK Native                  4 <input type="checkbox"/> Asian                  6 <input type="checkbox"/> Hawaiian/Pac. Islander                  5 <input type="checkbox"/> Other</p>	<p><b>EXAMINATION:</b> Client examined    0 <input type="checkbox"/> Yes    1 <input type="checkbox"/> No</p>																								
<p><b>REASONS FOR VISIT:</b> (patient-reported, check all that apply)                  2 <input type="checkbox"/> Routine Visit                  1 <input type="checkbox"/> Symptoms                  13 <input type="checkbox"/> STD Screening                  4 <input type="checkbox"/> <b>Exposed to CT</b>                  19 <input type="checkbox"/> <b>Exposed to GC</b>                  7 <input type="checkbox"/> Exposed to Other STD                  12 <input type="checkbox"/> Pregnancy Test Only                  11 <input type="checkbox"/> Rescreening: CT+                  20 <input type="checkbox"/> Rescreening: GC+</p>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>FINDINGS: FEMALE</b>                              (check all that apply)                              Cervical Findings                              1 <input type="checkbox"/> Normal Appearance                              3 <input type="checkbox"/> <b>Mucopurulence</b>                              4 <input type="checkbox"/> <b>Friability</b>                              5 <input type="checkbox"/> <b>Ectopy with inflam/edema</b>                              6 <input type="checkbox"/> <b>PID</b></p> </td> <td style="width: 50%; vertical-align: top;"> <p><b>FINDINGS: MALE</b>                              (check all that apply)                              Signs                              8 <input type="checkbox"/> Normal Appearance                              9 <input type="checkbox"/> Urethral Discharge                              11 <input type="checkbox"/> GC on Gram stain                              12 <input type="checkbox"/> Epididymitis</p> </td> </tr> </table>	<p><b>FINDINGS: FEMALE</b>                              (check all that apply)                              Cervical Findings                              1 <input type="checkbox"/> Normal Appearance                              3 <input type="checkbox"/> <b>Mucopurulence</b>                              4 <input type="checkbox"/> <b>Friability</b>                              5 <input type="checkbox"/> <b>Ectopy with inflam/edema</b>                              6 <input type="checkbox"/> <b>PID</b></p>	<p><b>FINDINGS: MALE</b>                              (check all that apply)                              Signs                              8 <input type="checkbox"/> Normal Appearance                              9 <input type="checkbox"/> Urethral Discharge                              11 <input type="checkbox"/> GC on Gram stain                              12 <input type="checkbox"/> Epididymitis</p>																						
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Note: Items in bold below the centerline are selective screening criteria for women

(REV. 10/2008) DOH 308-011

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