

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT



Lane County Public Health
 151 W 7th Avenue Room 310
 Eugene OR 97401
 (541) 682-4041
 (541) 682-2455 (Fax)

First Name:	Middle Name:	Last Name:
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Address:		
City:	State:	Zip:

Phone Number:	Alternate Phone Number:	Email Address:
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DOB:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> O	Pregnant: Yes: <input type="checkbox"/> ___ # of Weeks, No: <input type="checkbox"/>
Marital: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Partner <input type="checkbox"/> D <input type="checkbox"/> Unk	Reason for Exam: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam <input type="checkbox"/> Exposed to Infection <input type="checkbox"/> Pregnant	
Sexually Transmitted Disease: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Acute PID <input type="checkbox"/> Syphilis Date Tested: _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	Ethnicity: <input type="checkbox"/> Hispanic
Treatment: <input type="checkbox"/> Ceftriaxone/Rocephin ___mg <input type="checkbox"/> Cefixime/Suprax <input type="checkbox"/> Spectinomycin/Trobicin <input type="checkbox"/> Ciprofloxacin/Cipro <input type="checkbox"/> Cefpodoxime/Vantin <input type="checkbox"/> Benzathine Pen G Dose _____ Times _____ <input type="checkbox"/> Doxycycline X ___ days <input type="checkbox"/> Azithromycin/Zithromax <input type="checkbox"/> Erythromycin <input type="checkbox"/> Metronidazole/Flagyl <input type="checkbox"/> Other _____ RX Date: _____	Syphilis: <input type="checkbox"/> Primary (Chancere, etc.) <input type="checkbox"/> Secondary (Rash, etc.) <input type="checkbox"/> Early Latent (<1 yr) <input type="checkbox"/> Late Latent (>1 yr) <input type="checkbox"/> Congenital <input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Late Date Tested: _____ Serology Titer: <input type="checkbox"/> RPR _____ <input type="checkbox"/> VDRL _____ <input type="checkbox"/> FTA _____ <input type="checkbox"/> TP-PA _____ <input type="checkbox"/> Other: _____	Diagnosis Date: _____ Site(s): <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input type="checkbox"/> Ocular <input type="checkbox"/> Urine <input type="checkbox"/> Other _____ Date Tested: _____
	Sexual Partner Information: Name: _____ Address: _____ Phone: _____ DOB: _____ Sex: _____ Race: _____ Date Tested: _____ Test Results: _____ Treatment: _____ Date of Treatment: _____ Provider's Name: _____	
Other Sexually Transmitted Diseases: <input type="checkbox"/> Chancroid <input type="checkbox"/> Lymphogranuloma Venereum <input type="checkbox"/> 900	Provider: Provider Phone:	Provider Address:

Is the patient aware we may be calling: Yes: _____ No: _____
 Any special concerns that we need to know:

ONE DAY CRITERIA FOR REPORTING: Specified in OAR 333-19, each CASE or Suspected Case is reported to the local health department within one day from the time of identification of : Chlamydia, Gonorrhea, Syphilis, and Acute Pelvic Inflammatory Disease (PID).