



STATE OF HAWAII
 Department of Health
STD/AIDS Prevention Program
Sexually Transmitted Diseases (STD) Case Report

For official use only:
 Case No: _____ DIS# _____
 STDMIS INTERVIEW
 FIELD CONTACT Follow-up

Please complete this form to report Sexually Transmitted Diseases.

Patient's Last Name: _____ First Name _____ M.I. _____ AKA: _____
 Date of Birth _____ Age _____ Sex: () Transgender () Male () Female: Pregnant? () No () Yes _____ gestation wks Family Planning? () Yes () No
 Race _____ Ethnicity: () Hispanic () Non-Hisp Marital Status: () Single () Married () Separated () Divorced () Widowed
 Address: _____ City _____ State _____ Zip Code _____ Phone: _____
 Physician: _____ Address: _____ Phone: _____

I. PATIENT DIAGNOSIS AND TREATMENT: Refer to the CDC 2010 Sexually Transmitted Diseases Treatment Guidelines for alternative regimens and more information.

DISEASE/DIAGNOSIS	DATE OF TEST/DIAGNOSIS	TREATMENT
CHANCROID		TREATMENT DATE ____/____/____ <input type="checkbox"/> Azithromycin 1g po <input type="checkbox"/> Ciprofloxacin 500 mg po bid x3d <input type="checkbox"/> Ceftriaxone 250 mg IM <input type="checkbox"/> Erythromycin base 500mg po tid x 7 days Other (specify): _____
PELVIC INFLAMMATORY DISEASE <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Unspecified		TREATMENT DATE ____/____/____ Either <input type="checkbox"/> Ceftriaxone 250 mg IM, or <input type="checkbox"/> Cefoxitin 2g IM with Probenecid 1g po Plus <input type="checkbox"/> Doxycycline 100 mg po bid x 14 days Other (specify): _____
CHLAMYDIA TRACHOMATIS <input type="checkbox"/> PID (use PID section) <input type="checkbox"/> Uncomplicated		TREATMENT DATE ____/____/____ <input type="checkbox"/> Azithromycin 1g po single dose <input type="checkbox"/> Doxycycline 100 mg po bid x 7 days Other (specify): _____
GONORRHEA <input type="checkbox"/> PID (use PID section) <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Uncomplicated		TREATMENT DATE ____/____/____ Either <input type="checkbox"/> Ceftriaxone 250 mg IM, or <input type="checkbox"/> Cefixime 400 mg po single dose, or <input type="checkbox"/> Single dose injectable cephalosporin (specify type/dose): _____ Plus <input type="checkbox"/> Azithromycin 1g PO single dose Stat Other (specify): _____ <small>Dual treatment is recommended to mitigate emergence of cephalosporin resistant gonorrhea. Flouroquinolone is not recommended for the treatment of gonorrhea infections. If gonorrhea is documented and symptoms persists or recurs, test-of-cure culture is recommended to ensure patient does not have an untreated antibiotic resistant gonorrhea infection. Please call SPP immediately at (808) 733-9281 or after hours, (808) 224-1389, to report suspected case of treatment failure or patients whose isolates demonstrate decreased susceptibility to cephalosporin.</small>
SYPHILIS <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Early Latent (<1 year duration)		TREATMENT DATE ____/____/____ <input type="checkbox"/> Benzathine penicillin G, 2.4 million units IM in a single dose Other (specify): _____
<input type="checkbox"/> Late, Late Latent <input type="checkbox"/> Gumma <input type="checkbox"/> Cardiovascular		TREATMENT DATES #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ <input type="checkbox"/> Benzathine penicillin G, 7.2 million units total, administered as 3 doses of 2.4 million units IM, at 1-week intervals Other (specify): _____
<input type="checkbox"/> Neurosyphilis		TREATMENT DATE ____/____/____ <input type="checkbox"/> Aqueous crystalline penicillin G, 18-24 million units daily, administered as 3-4 million units IV q4hrs x 10-14 days Other (specify): _____

II. REQUEST TO TREAT PATIENT. If physician requests that DOH treat patient for this infection, please indicate treatment to be provided and sign as indicated.

Azithromycin 1g PO Cefixime 400 mg PO

Physician's Name: (PRINT) _____ Signature: _____ Date _____

III. LIST CASUAL AND/OR STEADY SEX PARTNERS THE PATIENT HAD IN PAST 60 DAYS.

Name/Address/Phone	Date of Birth/Age	Race	Sex	Marital Status	Last Exposure Dates	Was sex partner			Refer to DOH		For DOH Use only
						Examined?	Infected?	Treated?	Interview/Notify SP	Treat	
						Unknown No Yes: Date	Unknown No Yes: Dx	Unknown No Yes: Date Rx	No Yes	No Yes	
						Unknown No Yes: Date	Unknown No Yes: Dx	Unknown No Yes: Date RX	No Yes	No Yes	

IV. THE FOLLOWING ARE AVAILABLE FROM THE DOH AT NO CHARGE. Indicate quantity and FAX order to (808)- 733-9291.

Pamphlets on STD/HIV/AIDS. Foreign language translations are available. Foreign Language(s): _____ Quantity: _____
 2010 Sexually Transmitted Diseases Treatment Guideline
 Case Report Forms

For consultation regarding STDs, please call (808) 733-9281.

V. CALL, MAIL OR FAX REPORT TO:

Oahu: Hawaii STD Prevention Program 3627 Kilauea Avenue, Room 304 Honolulu, HI 96816 Phone: (808) 733-9281 FAX: (808) 733-9291	Kauai: Epidemiology Branch 3040 Umi Street Lihue, HI 96766 Phone: (808) 241-3563	Big Island: Epidemiology Branch 191 Kuawa St. Hilo, HI 96720 Phone: (808) 974-4247 FAX: (808) 974-4243	Maui, Lanai, Molokai: Epidemiology Branch 54 High Street Wailuku, HI 96793 Phone: (808) 984-8213
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