



County of Erie

CHRIS COLLINS
COUNTY EXECUTIVE

DEPARTMENT OF HEALTH

Anthony J. Billittier IV, M.D., FACEP
Commissioner of Health

February 3, 2010

Dear Provider:

Enclosed please find copies of the new Erie County Department of Health's sexually transmitted disease (STD) reporting forms. We are no longer using a triplicate form. The enclosed forms can be duplicated at your convenience or you may continue to request copies from our office.

You will notice several significant changes to the reporting form. To make reporting easier, we have included check boxes for many of the data items including diagnosis, specimen source, and laboratory test type. We have also included check boxes for the Centers for Disease Control's (CDC's) recommended treatment regimens for chlamydia and gonorrhea infections. Reporting of treatment information is essential for the success of our STD prevention and control programs

We hope you will find the reporting forms easy to use. As indicated on the reporting forms, reports may be faxed to our office or you may telephone reports to our secure reporting line. Either way, we thank you for your continued cooperation. If you have questions or concerns about STD reporting procedures, please do not hesitate to contact our office at (716) 858-7697.

Sincerely,

Heather A. Lindstrom, Ph.D.
Director
Epidemiology and Surveillance

Erie County Department of Health

Confidential Sexually Transmitted Disease Case Report



Fax Completed Forms to: 716-858-7964 or Call Our Secure Reporting Line: 716-858-7697



Patient Information				
Last Name:		First Name:		Middle Initial:
Address:		Zipcode:	Date of Birth (mm/dd/yy):	Age:
City/Town:			Telephone Number (with area code):	
Race: <input type="radio"/> American Indian/Alaskan <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> Other <input type="radio"/> Unknown		Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> Unknown		Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown
Reason for Exam: <input type="radio"/> Symptomatic <input type="radio"/> STD Contact <input type="radio"/> Routine screening <input type="radio"/> Other: _____		Was Patient Hospitalized for this Illness: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
		Hospital Name: _____		
		Date Admitted: _____		
		Date Discharged: _____		
Laboratory Data				
Date of Test (mm/dd/yy):		Specimen Source (v all that apply):		Laboratory Test Type:
Lab Confirmed (v all that apply): <input type="radio"/> Chlamydia <input type="radio"/> Gonorrhea		<input type="radio"/> Urine <input type="radio"/> Urethra <input type="radio"/> Other: _____		<input type="radio"/> NAAT <input type="radio"/> DNA Probe <input type="radio"/> Culture <input type="radio"/> Other: _____
		<input type="radio"/> Cervix <input type="radio"/> Blood		<input type="radio"/> RPR <input type="radio"/> TPPA <input type="radio"/> FTA-Abs <input type="radio"/> EIA
Chlamydia		Gonorrhea		Syphilis
Diagnosis (v all that apply): <input type="radio"/> Asymptomatic <input type="radio"/> Symptomatic—Uncomplicated <input type="radio"/> Pelvic Inflammatory Disease (cervical or adnexal tenderness) <input type="radio"/> Disseminated <input type="radio"/> Other: _____		Diagnosis (v all that apply): <input type="radio"/> Asymptomatic <input type="radio"/> Symptomatic—Uncomplicated <input type="radio"/> Pelvic Inflammatory Disease (cervical or adnexal tenderness) <input type="radio"/> Disseminated <input type="radio"/> Other: _____		Stage: <input type="radio"/> Primary (chancre, etc) <input type="radio"/> Secondary (rash, etc) <input type="radio"/> Early latent (<1 yr) <input type="radio"/> Late latent (>1 yr) <input type="radio"/> Congenital <input type="radio"/> Tertiary <input type="radio"/> Neurosyphilis
Treatment (v all prescribed): <input type="radio"/> Azithromycin, 1 g PO single dose <input type="radio"/> Doxycycline, 100 mg PO BID for 7 days <input type="radio"/> Erythromycin base, 500 mg PO QID for 7 days <input type="radio"/> Erythromycin ethylsuccinate, 800 mg PO QID for 7 days <input type="radio"/> Levofloxacin, 500 mg PO for 7 days <input type="radio"/> Ofloxacin, 300 mg PO BID for 7 days <input type="radio"/> Other treatment: _____		Treatment (v all prescribed): <input type="radio"/> Ceftriaxone, 250 mg IM single dose <input type="radio"/> Cefixime, 400 mg PO single dose <input type="radio"/> Ciprofloxacin, 500 mg PO single dose <input type="radio"/> Ofloxacin, 400 mg PO single dose <input type="radio"/> Other treatment: _____ Date Rx: _____		Treatment Given or Referred to: _____ _____ _____ Date Rx: _____
		<i>Note: if chlamydia has not been ruled out, patient should be treated for both gonorrhea and chlamydia.</i>		
Reporting Clinic Information				
Date:		Diagnosing Clinician:		
Facility Name:		Person Completing Form:		
Address:		Telephone:		
City, State, Zipcode:		Fax #:		

Comments: