Erie County Department of Health
Confidential Sexually Transmitted Disease Case Report
Secure Reporting Phone Line: (716) 858-7697 or Fax Form to: (716) 858-7964

Patient Information

Last Name:	First Name:	Middle Initial:	Date of Birth (mm/dd/yyyy)	Age:
Address:	City/Town:	Zip Code:	Telephone Number (with area code)	

Race: □ White □ Black □ Other □ American Indian/Alaskan □ Native Hawiian/Pacific Islander □ Asian: ________ □ Unknown

Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

Sex: □ Male □ Female □ Unknown

Pregnant: □ Yes □ No □ Unknown

Reason for Exam: □ Symptomatic □ STD Contact □ Routine Screening □ Other ________

Hospitalized for this illness: □ Yes □ No □ Unk Hospital:________________ Admitted ___/___/20___ Discharged ___/___/20___

Emergency Room Visit (Not hospitalized): □Yes □No □Unk Hospital:__________

Laboratory Data

Date of Test: ____/____/20_____

Lab Confirmed (√ all that apply) □ Chlamydia □ Syphilis □ Gonorrhea

Specimen Source: (√ all that apply) □ Urine □ Urethra □ Cervix □ Vagina □ Pharynx □ Rectum □ Blood □ Conjunctiva □ Other ________

Laboratory Test Type: (√all that apply) □ NAAT □ Culture □ RPR □ TPPA □ FTA-Abs □ EIA □ Other: ________

Chlamydia (CT)

Diagnosis: □ Asymptomatic □ Symptomatic □ PID □ Other: __________

Treatment Date: _____/_____/20____

Check Treatment Administered*:

□ Azithromycin, 1g orally in a single dose **OR**

□ Doxycycline, 100mg orally 2x/day for 7 days

Alternatives:

□ Erythromycin base 500mg orally 4x/day for 7 days **OR**

□ Erythromycin ethylsuccinate 800mg orally 4x/day 7 days **OR**

□ Levofloxacin 500mg orally 1x/day for 7 days **OR**

□ Ofloxacin 300mg orally 2x/day for 7 days **OR**

□ Other: ______________Why: ____________________

Expedited Partner Therapy (EPT) for CT or/and GC

Was EPT Offered? □ Yes □ No □ Unk

If Offered was EPT Provided? □ Yes □ No □ Patient Declined □ No - Other ________________ □ Unknown

If Not Offered,why? □Co-infected □MSM □Partner seen in office □ Partner to be seen in office □ Unk □ Other __________

Method EPT given? □ Med in hand □ Prescription □ Both □ Unk

Med in hand for how many partners? ______

Prescription for how many partners? ______

Gonorrhea (GC)

Diagnosis: □ Asymptomatic □ Symptomatic □ Other: __________ □ PID □ Disseminated

Treatment Date: ______/______/20_____

Check Treatment Administered*:

Uncomplicated GC of the CERVIX, URETHRA OR RECTUM

□ Ceftriaxone, 500mg IM single dose for person < 300 lbs **OR**

□ Ceftriaxone, 1g IM single dose for person ≥ 300 lbs

□ **AND IF** chlamydial infection has not been excluded, treat for CT with doxycycline 100mg orally twice daily for 7 days.

Alternative Treatment if ceftriaxone is not available:

□ Gentamicin 240 mg IM as a single dose PLUS Azithromycin 2g orally in a single dose **OR**

□ Cefixime 800mg orally as a single dose

□ **AND IF** chlamydial infection has not been excluded, treat for CT with doxycycline 100mg orally twice daily for 7 days

Uncomplicated GC of the PHARYNX

□ Ceftriaxone, 500mg IM single dose for person < 300 lbs **OR**

□ Ceftriaxone, 1g IM single dose for person ≥ 300 lbs

□ **AND IF** chlamydial coinfection is identified when pharyneal GC testing is performed, treat CT with doxycycline 100mg orally twice a day for 7 days.

Syphilis

Stage: □ Primary □ Secondary □ Early, Non Prim/Sec □ Late or Unk Duration □ Congenital

Test Results:

RPR: _______

TPPA:______

FTA-Abs: ______

EIA: _______

Treatment Date: _____/_____/20____

Treatment*: ______________

Reporting Information

Report Date:			If different:
Person Completing Form:	Reporting Facility Name:		Diagnosing Facility:
Address:	City/Town:	Zip Code:	Treating Facility:
Phone #	Fax #:		2/19/2021