



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

Form with sections: Patient Information, Laboratory Data, Chlamydia (CT), and Syphilis. Includes fields for name, DOB, address, race, ethnicity, sex, pregnancy, exam reason, hospitalization, test date, specimen source, lab test type, and treatment details.

* A complete list of treatment options can be found at https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm?s_cid=mm6950a6_w

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Erie County
 Department of
 Health



Public Health
 Prevent. Promote. Protect.

Gonorrhea (GC)	
Diagnosis: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> PID <input type="checkbox"/> Other: _____	Treatment Date: ____/____/20____
Check Treatment Administered*:	
Uncomplicated GC of Cervix, Urethra or Rectum: <input type="checkbox"/> Ceftriaxone 500mg IM single dose (< 300lbs) OR <input type="checkbox"/> Ceftriaxone 1g IM single dose (> 300lbs) <input type="checkbox"/> AND IF chlamydial infection has not been excluded, treat for CT w/ Doxycycline 100mg orally 2x/day × 7 days <i>Alternative if ceftriaxone unavailable:</i> <input type="checkbox"/> Gentamicin 240mg IM as a single dose + Azithromycin 2g orally in a single dose, OR <input type="checkbox"/> Cefixime 800mg orally as a single dose <input type="checkbox"/> AND IF chlamydial infection has not been excluded, treat for CT w/ Doxycycline 100mg orally 2x/day × 7 days	Uncomplicated GC of Pharynx: <input type="checkbox"/> Ceftriaxone, 500mg IM single dose for person < 300 lbs OR <input type="checkbox"/> Ceftriaxone, 1g IM single dose for person > 300 lbs <input type="checkbox"/> AND IF chlamydial coinfection is identified when pharyngeal GC testing is performed, treat CT with doxycycline 100mg orally twice a day for 7 days.

* A complete list of treatment options can be found at https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm?s_cid=mm6950a6_w

Expedited Partner Therapy (EPT) for CT and/or GC	
Was EPT offered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If Offered, was EPT provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient Declined <input type="checkbox"/> No – Other: _____ <input type="checkbox"/> Unknown Method EPT given? <input type="checkbox"/> Med in hand <input type="checkbox"/> Prescription <input type="checkbox"/> Both <input type="checkbox"/> Unknown Med in hand – # partners: _____ Prescription – # partners: _____	If Not Offered, why? <input type="checkbox"/> Co-infected <input type="checkbox"/> MSM <input type="checkbox"/> Partner seen in office <input type="checkbox"/> Partner to be seen in office <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____

Reporting Information		
Report Date (mm/dd/yyyy):	If different:	
Person Completing Form:	Diagnosing Facility:	
Reporting Facility Name:		
Address:	Treating Facility:	
City/Town: Zip Code:		
Phone #:	Fax #:	2/19/21 Remediated 4/22/26