

FAX completed form to (608) 246-5619

Additional information for completing on page 2

**A. PATIENT – Demographic Information**

Last Name		First Name		Middle Initial
Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnancy Status <input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Unknown	
Street Address				If yes, Number of weeks
City				Apartment Number
County of Residence		State		
Race <input type="checkbox"/> African American <input type="checkbox"/> Alaskan/Native American <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiiin/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Races		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Unknown		
Zip Code		Telephone Number with Area Code ( )		

**B. DISEASE CLASSIFICATION RELATED TO DIAGNOSIS**

<input type="checkbox"/> Syphilis	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Chancroid
<input type="checkbox"/> Congenital	<input type="checkbox"/> Salpingitis – Pelvic Inflammatory Disease (PID)	<input type="checkbox"/> Ophthalmia / Conjunctivitis	<input type="checkbox"/> Non CT/GC PID
<input type="checkbox"/> Primary (chancere present)	<input type="checkbox"/> Other (Arthritis, skin lesions, etc.)	Describe any symptoms:	
<input type="checkbox"/> Secondary (body rash, P&P)	<input type="checkbox"/> Uncomp. Urogenital (urethritis, cervicitis)		
<input type="checkbox"/> Early Latent (no symptoms < 1 yr duration)	<input type="checkbox"/> Resistant Gonorrhea (PPNG, TRNG, etc.)		
<input type="checkbox"/> Late Latent (no symptoms > 1 yr duration)			
<input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Other			

**C. LABORATORY TEST(S) RELATED TO CURRENT DIAGNOSIS**

Test Type (use one line per test)	Specimen Source (cervix, urethra, blood, etc.)	Test Result(s) (Mark all that apply)	
1		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	Titer 1: _____
2		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	Titer 1: _____
3		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> WR <input type="checkbox"/> QNS
4		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> WR <input type="checkbox"/> QNS
Date Specimen Collected (mm/dd/yyyy)		Date Specimen Analyzed (mm/dd/yyyy)	

Attending Physician / Provider Ordering Test

Name of Laboratory Performing Test(s)

Patient treated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date (mm/dd/yyyy)	*Expedited Partner Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Onset Symptoms (mm/dd/yyyy)	Date Report to LHD (mm/dd/yyyy)
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**D. TREATMENT (RX) INFORMATION**

<input type="checkbox"/> Benzathine penicillin G 2.4 m.u. IM x 1	<input type="checkbox"/> Amoxicillin 500 mg PO TID x 7d	<input type="checkbox"/> Cefixime 400mg PO x 1
<input type="checkbox"/> Benzathine penicillin G 2.4 m.u. IM x 3	<input type="checkbox"/> Azithromycin 1 gm PO x 1	<input type="checkbox"/> Other, list: _____
<input type="checkbox"/> Doxycycline 100mg PO BID for 7d	<input type="checkbox"/> Ceftriaxone 125mg IM x 1	_____ *EPT - Azithromycin 1 gm PO x 1 _____ *EPT - Cefixime 400mg PO x 1 _____ *Other, list: _____ *EPT List number of doses.____
<input type="checkbox"/> Doxycycline 100mg PO BID for 10d	<input type="checkbox"/> Ceftriaxone 250mg IM x 1	
<input type="checkbox"/> Doxycycline 100mg PO BID for 14d	<input type="checkbox"/> Erythromycin base 500mg PO TID 7d	
<input type="checkbox"/> Doxycycline 100mg PO BID for 28d	<input type="checkbox"/> Erythromycin base 500mg PO QID 7d	
Person Reporting	Telephone number ( )	Local Health Department(LHD) Name
Agency Reporting	Telephone number ( )	
Street Address		
City, State and Zip		Date Received by LHD (mm/dd/yyyy)

Comments:

## Information for Completing Sexually Transmitted Diseases Laboratory and Morbidity Epidemiologic Case Report

Information reported on this form is authorized by Wisconsin Statute 252.11. All information contained in this report is confidential except as may be needed for the purpose of investigation, control and prevention of communicable diseases.

### General Instructions

This STD case report form is to be used by: laboratories, physicians, hospitals, STD clinics and, Local Health Departments (LHDs) or other agencies within the state of Wisconsin to report suspected or confirmed Sexually Transmitted Diseases. This report is mandated under the provisions of section 252.11 of the Wisconsin Statutes. As specified in rules promulgated by the department, ALL information (Laboratory and Morbidity) is to be reported to the Local Health Department / Officer in the county that the patient resides **within 72 hours** and Local Health Departments need to report to the Wisconsin Department of Health Services weekly.

### Retention and Distribution

This form is also available as an MS Word fillable format available in the DHS Forms Index <http://dhs.wisconsin.gov/forms/F4/f44243.doc>.

### Reportable Sexually Transmitted Diseases (as of 03/01/2008)

Chancroid	Sexually Transmitted Pelvic Inflammatory Disease (PID)
Chlamydia (CT)	Syphilis – (all stages)
Gonorrhea (GC)	

### Specific Instructions

**SECTION A: Patient Demographic Information:** Complete ALL patient information. For date of birth use month, day, and year (e.g. 01-01-2008). Do not omit any demographic information. Include a complete mailing address, city, county, state, zip code and telephone number. When reporting STDs for females make sure to note pregnancy status and number of weeks pregnant.

**SECTION B: Disease Classification Related to Diagnosis:** Check box for each disease suspected or confirmed. See CDC treatment guidelines for additional case classification information. To report PID associated with Chlamydia (CT) or Gonorrhea (GC), check box(es) in disease and salpingitis.

**SECTION C: Laboratory Test(s) Related to Diagnosis:** Use a single line to report information on each test. There is enough space to report four results on each case report form. If reporting more than four positive tests on the same individual, use an additional form and attach it to the original form.

**Test Type(s):** Indicate the type of test used to confirm diagnosis. Example: (GC-LCR, CT-EIA, GC-AMA VDRL, FTA-ABS)

**Specimen source:** Indicate anatomical specimen collection site. Example: (Cervix, urethra, blood, or urine)

**SECTION D: Treatment (Rx) Information:** Check all Rx related to this case report. If reporting other Rx, follow Rx format used on this form. Include the Name (doxy., ceft., etc.), Type (PO, IM, BID), Amount given (100mg, 2.4 m.u. etc.) and number of days (x 1 d, x 7 d etc.) provided. Provide complete information on Treating/Attending physician. Use month, day, and year (e.g. 01-01-2008) for date treated, date onset of symptoms, and date reported to Local Health Officer. Expedited Partner Therapy\* (EPT) allows medical providers to prescribe, dispense, or furnish medication to partners of patients diagnosed with trichomoniasis, gonorrhea, or *Chlamydia trachomatis* infection without a medical evaluation of the partner. EPT should be used to supplement not supplant current STD control efforts described in section 252.11 of the Wisconsin statutes. More information can be found at <http://dhs.wisconsin.gov/communicable/STD/INDEX.HTM>."

**See the current CDC Sexually Transmitted Diseases Treatment Guidelines, found at:** <http://www.cdc.gov/std/treatment/>

Indicate the name, title, telephone number and mailing address for the individual completing the report so that program staff may contact the individual completing the form, or the attending physician if there are questions regarding the case report.

**FAX instructions:** Fax completed forms to (608) 246-5619. Call (608) 243-0411 if you have questions.

**Partner referral/interview:** Use the CDC Field Record form (73.2936S) for case management to document information on sex partners, suspects and associates, and prioritize your work. Call the STD Section number above to order new forms. When a named partner, suspect or associate resides outside of the initiating agency's jurisdiction (disposition=K), a Field Record form should be completed and routed to the appropriate LHD for epidemiologic follow-up, or to the Division of Public Health, STD Control Section to forward out of state, at:

Wisconsin Division of Public Health  
STD Control Section  
1 West Wilson Street, Rm # 339  
Madison WI 53703-2659