Hudson Valley Regional Sexually Transmitted Infection (STI) Collaborative Reporting Form

Rev. 06/2023

Last Name: _____ First Name: _____ Date of Birth: ___/___/___

Phone #: _____ Address:_____

Emergency Contact: _____ Sex: ☐ Male ☐ Female ☐ Transgender: M to F OR F to M

Race/Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Unknown ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Unknown ☐ Other: _____

Occupation: ☐ Unemployed ☐ Employed/Employer: _____ Sex of Partners: _____

Exam Date: ___/___/___ ☐ Screening ☐ Contact to STD ☐ Symptoms/Date of 1st Symptom: ___/___/___

☐Discharge ☐Lower Abdominal Pain ☐Rash ☐Bumps ☐Itching
☐Painful Urination ☐Abnormal Bleeding ☐Burning Sensation ☐Testicular Pain ☐Genital Warts
☐Other _____

Pregnant: ☐ Yes ☐ No

Outcome: ☐ Live/Due Date: ___/___/___ ☐ Termination/Date: ___/___/___ ☐ Miscarriage/Date: ___/___/___ ☐ Unknown

Father of the Baby (FOB): _____ FOB Phone: _____ ☐ EPT ☐ MDT

Was a HIV test offered at this visit? ☐ Yes ☐ Yes, patient declined ☐ No ☐ Unknown

Last known HIV test ___/___/___ ☐ On PrEP ☐ Referral for PrEP given

Do NOT report HIV results on this form

NYS Law: Every person 13 and older should be offered an HIV test

CHLAMYDIA – MUST BE REPORTED WITHIN 5 DAYS OF POSITIVE LAB REPORT

Test Date: ___/___/___ ☐ Blood ☐ Cervical ☐ Urine ☐ Rectal ☐ Throat

Treatment Date: ___/___/___

Expedited Partner Therapy ☐ No ☐ Med in Hand ☐ Rx ☐ Both ☐ Unknown # of Rx Given:_____

☐ Doxycycline (Vibramycin) 100mg PO 2x/day x 7 days **OR** ☐ Azithromycin (Zithromax) 1gm PO Single Dose ☐ Other Rx. Given

GONORRHEA – MUST BE REPORTED WITHIN 24 HOURS OF POSITIVE LAB REPORT

Test Date: ___/___/___ ☐ Blood ☐ Cervical ☐ Urine ☐ Rectal ☐ Throat

Treatment Date: ___/___/___ ☐ **Rx. Given**

Expedited Partner Therapy ☐ No ☐ Med in Hand ☐ Rx ☐ Both ☐ Unknown # of Rx Given:_____

☐ Ceftriaxone (Rocephin) 500mg IM Single Dose ☐ Doxycycline (Vibramycin) 100mg PO 2x/day x 7 days

☐ Azithromycin (Zithromax) 2gm PO Single Dose AND Gentamicin 240 mg IM Single Dose (**ONLY** to be given with patient documented allergy/pregnancy)

☐ Cefixime 800mg PO Single Dose **AND** Doxycycline (Vibramycin) 100mg PO 2x/day x 7 days **(MUST** have Test of Cure in 1 week)

SYPHILIS – MUST BE REPORTED WITHIN 24 HOURS OF POSITIVE LAB REPORT

Diagnosis:

☐ **Primary** - Chancre ☐ **Secondary** – Plantar palmer or bilateral body rash ☐ **Early** - No sex & new (+) test within 1 year

☐ Benzathine Penicillin 2.4 million units IM Single Dose Treatment Date: ___/___/___

☐ **Latent -** Benzathine Penicillin 2.4 million units IM X 3 Doses Treatment Date: ___/___/___

Test Date: ___/___/___ RPR: _____

RPR Confirmed with ☐ TPPA - Reactive /Non-Reactive ☐ IgG/CIA/EIA – Reactive/Non-Reactive ☐ CSF – Reactive/Non-Reactive

☐ Doxycycline (Vibramycin) 100mg PO 2x/day x 14 days (**MUST** be given with patient documented PCN Allergy)

☐ Doxycycline (Vibramycin) 100mg PO 2x/day x 28 days (**MUST** be given with patient documented PCN Allergy)

☐ Not Treated ☐ Previous hx of tx Date**:** ____/____/____

*****FTA needs confirmation with TPPA or IgG*** *** Titer Checks MUST be done to ensure successful treatment *****

Reporting Physician: _____ Date of Report: ___/___/___

Physician Address: _____ Telephone and Fax: _____