

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED INFECTIONS (STI)**

All providers who diagnose or treat a reportable sexually transmitted infection are required to report to the local health authority within seven (7) days. Complete all spaces or check all boxes as appropriate. Shaded areas are not required by law, but necessary for appropriate identification or follow up.

Patient's Name (Last, First, MI.)		Date of Birth	Age	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Pregnant? N <input type="checkbox"/> Y <input type="checkbox"/> # of weeks
Address (Street, City, State, Zip)			Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race <i>check all that apply</i> W <input type="checkbox"/> B <input type="checkbox"/> AIS <input type="checkbox"/> AI <input type="checkbox"/> PI <input type="checkbox"/>	
Telephone:	Marital Status S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>	Employment	Sex of Partners: F <input type="checkbox"/> M <input type="checkbox"/> Both <input type="checkbox"/>		SSN/Medical record No.
Provider Type: <input type="checkbox"/> Private Phy/Primary Care <input type="checkbox"/> Family Planning <input type="checkbox"/> Prenatal/OB clinic <input type="checkbox"/> Other clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Emergency <input type="checkbox"/> HIV Site <input type="checkbox"/> STD Clinic <input type="checkbox"/> Drug Treatment <input type="checkbox"/> TB clinic <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Laboratory <input type="checkbox"/> Blood/Plasma <input type="checkbox"/> Other					
Exam Date:	Exam Reason: <input type="checkbox"/> Volunteer <input type="checkbox"/> Referred by Partner <input type="checkbox"/> Referred by another provider <input type="checkbox"/> DIS Partner Referral <input type="checkbox"/> DIS Suspect Referral <input type="checkbox"/> Prenatal <input type="checkbox"/> Delivery <input type="checkbox"/> Screening in Jail/Prison <input type="checkbox"/> Other screening				
100 Chancroid		200 Chlamydia (Not PID)		300 Gonorrhea (Not PID)	
<input type="checkbox"/> Urethral <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervical <input type="checkbox"/> Rectal <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Ophthalmia Treatment Date: Treatment Given: <input type="checkbox"/> Azithromycin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Other: Dosage: <input type="checkbox"/> 1 gram <input type="checkbox"/> 250 mg IM <input type="checkbox"/> Other: <input type="checkbox"/> No Treatment Given		<input type="checkbox"/> Urethral <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervical <input type="checkbox"/> Rectal <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Resistant GC Type of Test: Treatment Date: Treatment Given: <input type="checkbox"/> Azithromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: Dosage: <input type="checkbox"/> 1 gram <input type="checkbox"/> 100 mg BID X 7 days <input type="checkbox"/> Other: <input type="checkbox"/> No Treatment Given		<input type="checkbox"/> Urethral <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervical <input type="checkbox"/> Rectal <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Resistant GC Type of Test: Treatment Date: Treatment Given: <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Other: Dosage: <input type="checkbox"/> 500 mg IM <input type="checkbox"/> Other: <input type="checkbox"/> No Treatment Given	
490 Pelvic Inflammatory Disease		600 Lymphogranuloma Venereum (LGV) <input type="checkbox"/>			
Disease: <input type="checkbox"/> Chlamydial <input type="checkbox"/> Gonococcal <input type="checkbox"/> Other or Unknown Etiology Type of Test: Treatment Date: Treatment Given: <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Doxycycline <input type="checkbox"/> Metronidazole <input type="checkbox"/> Other: Dosage: <input type="checkbox"/> 500 mg IM <input type="checkbox"/> 100 mg BID X 14 days <input type="checkbox"/> 500 mg BID X 14 days <input type="checkbox"/> Other: <input type="checkbox"/> No Treatment Given		<input type="checkbox"/> Primary (lesions)* report within 24 hrs <input type="checkbox"/> Secondary (symptoms) * report within 24 hrs <input type="checkbox"/> Early Latent (< 1 year) <input type="checkbox"/> Late Latent (> 1 year) <input type="checkbox"/> Late (with symptoms) <input type="checkbox"/> Congenital Syphilis Y N Unk <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neurologic Involvement Type of Test: Treatment Date(s): Treatment Given: <input type="checkbox"/> Benzathine penicillin G <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: Dosage: <input type="checkbox"/> 2.4 mu IM X 1 <input type="checkbox"/> 2.4 mu IM X 3 <input type="checkbox"/> 100 mg BID X <input type="checkbox"/> 14 days <input type="checkbox"/> 28 days <input type="checkbox"/> Other: <input type="checkbox"/> No Treatment Given		900 <input type="checkbox"/> HIV Non- AIDS <input type="checkbox"/> HIV with AIDS <input type="checkbox"/> Non-Reactive HIV Test Results Type of Test: Date of Result: Reporting HIV on this document serves as proof of timely report; however, the health department requires additional information on HIV patients. Reporting Address: <div style="border: 1px dotted black; padding: 10px; min-height: 100px;"> <p align="center">(Local Health Authority place mailing information here)</p> </div>	
Reported By:					
Name		Office Address		City	
				Phone Number	

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Use the spaces below to report your patient's sexual or needle sharing partner(s) for confidential notification by a Disease Intervention Specialist (DIS).
When those listed below are notified of exposure, the DIS will not reveal your patient's identity.

Please consult me or my designated staff before contacting my patient: <input type="checkbox"/>						
Designated Staff Person:		Telephone:		Extension:	Best time to call me or my staff:	
Partner's Name (Last, First, MI.)		Nickname or alias:	Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race	Sex	DOB or approximate age
Partner's Address (Street, Apartment, City, State)		Telephone: Home: Work:		Best time to call or visit partner:		
Date of last exposure to patient: Partner's Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Partner's Place of Employment: Work Hours:		Treatment given: Date:				
Partner's Name (Last, First, MI.)		Nickname or alias:	Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race	Sex	DOB or approximate age
Partner's Address (Street, Apartment, City, State)		Telephone: Home: Work:		Best time to call or visit partner:		
Date of last exposure to patient: Partner's Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Partner's Place of Employment: Work Hours:		Treatment given: Date:				
Partner's Name (Last, First, MI.)		Nickname or alias:	Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race	Sex	DOB or approximate age
Partner's Address (Street, Apartment, City, State)		Telephone: Home: Work:		Best time to call or visit partner:		
Date of last exposure to patient: Partner's Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Partner's Place of Employment: Work Hours:		Treatment given: Date:				



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