MIDIS ID: _____

DPHHS STD CASE REPORTING FORM: CHLAMYDIA

PATIENT TAB Demographic Information

First Name:	Last Name:	Date of Birth: Age:	
Street Address:	City: County:	State:	ZIP Code:
Current gender: ☐ Male ☐ Female ☐Transgender ☐ M to F ☐ F to M ☐ Refused		Cell Number: _____ Other Number: _____	
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐Refused		Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused	

CASE INFO TAB Reporting Information

Investigation Start Date:	Diagnosis Date:	Diagnosis Reported to CDC: ☐Chlamydia ☐Gonorrhea ☐Syphilis
Date of Report:	Confirmation Date:	PID: Y N U Conjunctivitis: Y N U
Earliest Date Report to County:	Case Status: ☐ Confirmed ☐ Probable	Was Patient Hospitalized? ☐ Yes ☐ No ☐ Unknown
Earliest Date Report to State:	Reporting Source:	Patient Lost to Follow-up:

CASE MANAGEMENT TAB Case Management

Eligible for Notification of Exposure:	Exam Date:	Dispositioned by:
Investigator: Date Assigned:	Treatment Start Date: **Was appropriate treatment administered? ☐ Y ☐ N**	Interviewer: Interview Date Assigned: Interview Status:
Exam Reason:	Disposition:	Date Closed:
	Disposition Date:	Closed by:

GENERAL COMMENTS

MIDIS ID: _____

CORE INFORMATION TAB Other STDs, Partners and Pregnancy Information

Is the patient pregnant? ☐Y ☐ N ☐U	HIV Status
Pregnant at Exam: ☐Y ☐ N ☐U Number of Weeks:	☐Negative ☐Newly Diagnosed ☐Prior Positive—Not previously known ☐Unknown ☐Prior Positive—New STD or Pregnancy ☐Other ☐Prior Positive—Contact to STD/HIV Case

Partner Information

Number of Sex Partners	**Past Year**			**Interview Period**		
Female	Number:	☐Unknown	☐Refused	Number:	☐Unknown	☐Refused
Male	Number:	☐Unknown	☐Refused	Number:	☐Unknown	☐Refused
Transgender	Number:	☐Unknown	☐Refused	Number:	☐Unknown	☐Refused

Collect contact information for partners. When conducting partner interview, please use "*STD Contact Record Form*"

No.	**Partner Name**	**Gender**	**Exposure Time**	**Contact Info**

Previous STD History ☐ Y *(please indicate below)* ☐ N ☐ Refused ☐ Unknown

Condition	Diagnosis Date	Treatment Date	Confirmed

Referred to Testing

Referred to HIV Testing: ☐ Y ☐ N	Referral Date:	HIV (900) Test: ☐Y ☐N ☐ Refused ☐ Didn't Ask ☐ Unknown	HIV Test Result:

Pre-exposure Prophylaxis for HIV (PrEP)

Is the client currently on pre-exposure prophylaxis (PrEP)? ☐Y ☐N ☐Unknown	Has the client been referred to a PrEP Provider? ☐Y ☐N ☐Partner Declined ☐Partner on PrEP

MANAGE ASSOCIATIONS BUTTON Treatment Information

Add New Treatment Button

Was treatment given for this infection? ☐Y ☐N Provider/ Facility:	
Chlamydia: ☐ 1g Azithromycin ☐ 100mg Doxycycline BID x _____ days ☐ Other:	**Gonorrhea**: ☐ 500mg IM Ceftriaxone ☐ 800mg Cefixime ☐ Other:

CONTACT RECORDS TAB Interview Record

Add New Interview Button

Date of Interview:	Interview Type: ☐ Initial/Original ☐Presumptive ☐ Re-Interview
Interview Location: ☐Clinic ☐Field ☐Internet ☐Other ☐Telephone	Name of Interviewer: Were contacts named at this interview? ☐ Yes ☐ No