

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES (STD)**

All providers who diagnose or treat a reportable sexually transmitted disease 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 check all that apply 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 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	200 Chlamydia (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"/> 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	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 <input type="checkbox"/> Resistant GC Treatment Date: _____ Treatment Given: <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Other: _____ Dosage: <input type="checkbox"/> 250 mg IM <input type="checkbox"/> 1 gram <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Treatment Given	490 Pelvic Inflammatory Disease Disease: <input type="checkbox"/> Chlamydial <input type="checkbox"/> Gonococcal <input type="checkbox"/> Other or Unknown Etiology Treatment Date: _____ Treatment Given: <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____ Dosage: <input type="checkbox"/> 250 mg IM <input type="checkbox"/> 100 mg BID X 14 days <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Treatment Given		
600 Lymphogranuloma Venereum (LGV) <input type="checkbox"/> Treatment Date: _____ Treatment Given: <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____ Dosage: <input type="checkbox"/> 100 mg BID X 21 days <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Treatment Given	700 Syphilis <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 Treatment Date: _____ 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 HIV Non- AIDS <input type="checkbox"/> HIV with AIDS <input type="checkbox"/> 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 dashed black; padding: 5px; margin: 5px 0;"> Waco – McLennan County Public Health District Morbidity Report (J – 27) Melanie Kaluza, RN 225 West Waco Drive Waco, Texas 76707 Phone: (254) 750-5478 Fax: (254) 750-5484 </div> <p align="center" style="font-size: 1.2em; font-weight: bold; margin-top: 20px;">PLEASE ATTACH COPY OF LAB RESULTS</p>			

Reported By: _____

Name _____ Office Address _____ City _____ Phone Number _____