

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

Rev. 06/2021

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 (**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: \_\_\_\_\_