LOUISIANA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES

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Submitter Information:
Facility: _____
Address: _____
City/State/Zip: _____
Phone: _____
Name of Person Reporting: _____

PATIENT INFORMATION:

Chart or Computer #: _____
Name (print): Last _____ First _____ MI _____
Address: _____
City/State/Zip: _____
Patient Home Phone: _____ Patient Work Phone: _____ Patient Cell Phone: _____
DOB (MM/DD/YYYY): _____ SSN: _____ Emergency Contact: _____
Gender: ☐ MALE ☐ FEMALE If female, pregnancy status: ☐ Not Pregnant ☐ Pregnant ____ mos.
Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other/Unk Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

CHLAMYDIA	GONORRHEA	SYPHILIS	OTHER
☐ Uncomplicated ☐ Ophthalmia neonatorum ☐ Oral / Pharyngeal ☐ Rectal ☐ Pelvic Inflammatory Disease (PID) ☐ Pneumonia ☐ Other (specify) _____ _____	☐ Uncomplicated ☐ Disseminated Gonococcal Infection (DGI) ☐ Ophthalmia neonatorum ☐ Oral / Pharyngeal ☐ Rectal ☐ Other Resistant Strain ☐ Pelvic Inflammatory Disease (PID) ☐ Penicillinase – Producing *Neisseria gonorrhoeae* (PPNG)	**NOTE: Call 504-568-7474 to report early syphilis, then follow-up with form.** ☐ Primary (Lesions) ☐ Secondary (Rashes) ☐ Early Latent (<1year) ☐ Late Latent (>1 year) ☐ Tertiary - Cardiovascular ☐ Tertiary - Neurosyphilis ☐ Congenital ☐ Unknown stage	☐ Chancroid ☐ Granuloma Inguinale ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Herpes Simplex Virus **(only report neonates)** ☐ Lymphogranuloma venereum ☐ Other (specify) _____ _____
Date of Test(s):	**Date of Test(s):**	**Date of Test(s):**	**Date of Test(s):**
Reporting Laboratory:	**Reporting Laboratory:**	**Reporting Laboratory:**	**Reporting Laboratory:**
Test(s) Conducted: ☐ Culture ☐ NAATs ___ Urine ___ Swab ☐ Nucleic Acid Probe ☐ Point-of-Care Test ☐ Other (specify) _____ _____	**Test(s) Conducted:** ☐ Culture ☐ NAATs ___ Urine ___ Swab ☐ Nucleic Acid Probe ☐ Gram Stain ☐ Other (specify) _____ _____	**Test(s) Conducted:** ☐ IgG_____ ☐ RPR_____ ☐ VDRL_____ ☐ MHATP_____ ☐ FTA_____ ☐ Other (specify) _____	**Test(s) Conducted:** ☐ _____ ☐ _____ ☐ _____
Date of Treatment:	**Date of Treatment:**	**Date of Treatment:**	**Date of Treatment:**
Treatment ☐ Azithromycin 1 gm orally x 1 dose ☐ Doxycycline 100 mg BID x 7 days ☐ Other: _____ ☐ Other: _____ IF PATIENT IS PREGNANT ☐ Azithomycin 1 gm orally x 1 dose ☐ Erythromycin 500 mg QID x 7 days ☐ Amoxicillin 500 mg TID x 7 days ☐ Other: _____	**Treatment** ☐ Cefixime 400 mg orally x 1 dose ☐ Ceftriaxone 125 mg IM x 1 dose ☐ Ceftriaxone 250 mg IM x 1 dose ☐ Ofloxacin 400 mg orally x 1 dose ☐ Levofloxacin 250 mg orally x 1 dose ☐ Other (specify) _____ _____ IF PATIENT IS PREGNANT: ☐ Cefixime 400 mg orally x 1 dose ☐ Ceftriaxone 125 mg IM x 1 dose ☐ Ceftriaxone 250 mg IM x 1 dose ☐ Other (specify) _____ _____	**Treatment** ☐ 2.4 million units Benzathine penicillin G (BIC) X 1 ☐ 2.4 million units Benzathine penicillin G (BIC) X 3 ☐ Other: _____ Date given: ___/___/_____	**Treatment** ☐ _____ ☐ _____ ☐ _____ ☐ _____
Partner Information: # Treated by provider: _____ # Referred to Health Dept: _____	**Partner Information:** # Treated by provider: _____ # Referred to Health Dept: _____	**Partner Information:** # Treated by provider: _____ # Referred to Health Dept: __	**Partner Information:** # Treated by provider: _____ # Referred to Health Dept: _____

Has this patient had a previous sexually transmitted disease in the last 12 months? ☐ Yes ☐ No If yes, disease: _____

Mail to: Louisiana Office of Public Health STD Control Program PO Box 60630 New Orleans, LA 70160