New Hampshire Confidential STD Reporting Form

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all
Department of Health & Human Services

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** ____ **DOB:** ____/____/____

Address: _____

City/State/Zip: _____ **Employer:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Birth Sex: ☐ Male ☐ Female **Current Gender:** ☐ Male ☐ Female ☐ Transgender ☐ **Pregnant** ☐ **Not Pregnant**

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ Amer Indian/Alaskan Native ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown **Primary language:**_____ **DRUG ALLERGIES:**_____

****** Please indicate <u>all</u> Sexually Transmitted Disease testing performed by your facility ******

CHLAMYDIA

☐ Asymptomatic
☐ Symptomatic onset: _____
- ☐ Discharge
- ☐ Dysuria
- ☐ Rash
- ☐ Pain (specify) _____
- ☐ Other (specify) _____

☐ Pelvic Inflammatory Disease

Date of Test(s): _____/_____/_____
Reporting Lab: _____
Result: ☐ **Positive** ☐ **Negative**

Specimen Source

☐ Urine ☐ Rectum
☐ Cervix/Vagina ☐ Urethra
☐ Pharynx
☐ Other _____

GONORRHEA

☐ Asymptomatic
☐ Symptomatic onset: _____
- ☐ Discharge
- ☐ Dysuria
- ☐ Rash
- ☐ Pain (specify) _____
- ☐ Other (specify) _____

☐ Pelvic Inflammatory Disease

Date of Test(s): _____/_____/_____
Reporting Lab: _____
Result: ☐ **Positive** ☐ **Negative**

Specimen Source

☐ Urine ☐ Rectum
☐ Cervix/Vagina ☐ Urethra
☐ Pharynx
☐ Other _____

SYPHILIS

☐ Primary (lesions)
☐ Secondary (rash)
☐ Early Non-Primary Non-Secondary (asymptomatic <1year)
☐ Unknown Duration or Late (>1 year)
☐ Unknown stage

Onset Date: _____
Symptoms on exam:
_____
_____
_____
_____
_____
_____

Non-Treponemal Tests*
Date: ____/____/____
Reporting Lab _____
RPR: ☐ Pos ☐ Neg
Titer: 1: _____
VDRL: ☐ Pos ☐ Neg
Titer: 1: _____

Treponemal Tests*
Date: ____/____/____
Reporting Lab _____
FTA-ABS: ☐ Pos ☐ Neg
TPPA: ☐ Pos ☐ Neg
Other: ☐ Pos ☐ Neg
Specify: _____

***Both Non-Treponemal and Treponemal tests REQUIRED**

****** For full CDC Treatment Guidelines, see https://www.cdc.gov/std/tg2015/default.htm ******

Treatment

Date: _____/_____/_____
☐ Azithromycin 1 gm orally x 1 dose
☐ Doxycycline 100 mg BID x 7 days
☐ Other: _____

If patient is pregnant:
☐ Azithromycin 1 gm orally x 1 dose
☐ Erythromycin 500 mg QID x 7 days
☐ Other: _____

Treatment

Date: _____/_____/_____
☐ Ceftriaxone 250 mg IM x 1 dose
AND Azithromycin 1 gm orally x 1 dose

☐ Other: _____

<u>Only</u> if ceftriaxone is not available:
☐ Cefixime 400 mg orally once **AND** Azithromycin 1 gm orally x 1 dose

Treatment

Date: _____/_____/_____
☐ 2.4 mu Benzathine penicillin G (BIC) X 1 dose
☐ 2.4 mu Benzathine penicillin G (BIC) X 3 doses at 1 week intervals
☐ Other: _____

<u>Only</u> if penicillin allergy or BIC unavailable:
☐ Doxycycline 100 mg orally BID x 14 days
☐ Doxycycline 100 mg orally BID x 28 days

EPT (Expedited Partner Therapy)/Partner Prophylaxis (given by provider):

Was medication prescribed to the patient for their partner(s)? ☐ **No** ☐ **Yes** **Number of partners prescribed EPT** _____

For more information: https://www.dhhs.nh.gov/dphs/bchs/std/ept.htm

Date of last negative HIV test: ____/____/____ ☐ **Rapid** ☐ **EIA** ☐ **4th Gen** ☐ **Unknown** ☐ _____

Is patient on PrEP (Pre-exposure prophylaxis): ☐ **Yes** ☐ **No** ☐ **Unknown**

For HIV positive patients not previously reported, <u>please mail</u> the HIV/AIDS Report Form: http://www.dhhs.nh.gov/dphs/cdcs/forms.htm

Risk Information (Check all that apply, if known):

Partner Sex: ☐ Male ☐ Female ☐ Both ☐ Transgender ☐ Unknown

Injection drug use: ☐ Current (within 6 months) ☐ Ever ☐ Unknown

Additional Notes:
_____
_____

Healthcare Provider: _____ **Provider Facility:** _____ **Phone:** _____
Person Reporting: _____ **Phone:** _____ **Date:** _____

Mail completed forms to: NH DHHS, DPHS, Bureau of Infectious Disease Control, 29 Hazen Dr., Concord, NH 03301 **– OR –**

Fax completed forms to: 603-271-0545 **Additional Forms available at** http://www.dhhs.nh.gov/dphs/cdcs/forms.htm ***Version 3/2018***

<u>NH RSA 141-C</u> and <u>He-P300</u> mandate reporting of chlamydia, gonorrhea, syphilis, and HIV by all physicians, labs, and health care providers.
We request prompt reporting of suspect and confirmed cases within 72 hours of diagnosis. All reports are handled under strict confidentiality standards.