

New Hampshire Confidential STD Reporting Form



PATIENT INFORMATION

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

Address: _____

City/State/Zip: _____ Employer: _____

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

Sex: Male Female Pregnant - due date: ____/____/____ Not Pregnant Primary language: _____

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

Ethnicity: Hispanic Non-Hispanic Marital Status: Single Married Divorced

*****Please indicate all Sexually Transmitted Disease testing performed by your facility*****

CHLAMYDIA

- Asymptomatic
- Symptomatic onset: _____
 - Discharge
 - Dysuria
 - Rash
 - Pain (specify) _____
 - Swelling (specify) _____
- Pelvic Inflammatory Disease

Date of Test(s): ____/____/____

Reporting Lab: _____

Result: Positive Negative

Specimen Source

- Urine Rectum
- Cervix Urethra
- Pharynx Unknown
- Other _____

GONORRHEA

- Asymptomatic
- Symptomatic onset: _____
 - Discharge
 - Dysuria
 - Rash
 - Pain (specify) _____
 - Swelling (specify) _____
- Pelvic Inflammatory Disease

Date of Test(s): ____/____/____

Reporting Lab: _____

Result: Positive Negative

Specimen Source

- Urine Rectum
- Cervix Urethra
- Pharynx Unknown
- Other _____

SYPHILIS

- Primary Onset Date: _____
- Secondary Symptoms: _____
- Early Latent (<1 year) _____
- Late Latent (>1 year) _____
- Congenital _____
- Unknown stage _____

Non-Treponemal Tests

Date: ____/____/____

Reporting Lab: _____

RPR: Pos Neg

Titers: 1: _____

VDRL: Pos Neg

Titers: 1: _____

Treponemal Tests

Date: ____/____/____

Reporting Lab: _____

IgG: Pos Neg

FTA-ABS: Pos Neg

TPPA: Pos Neg

Other: Pos Neg

Specify: _____

*****Check all treatments that apply (including presumptive treatment)*****

Treatment

Date: ____/____/____

- Azithromycin 1 gm orally x 1 dose
- Doxycycline 100 mg BID x 7 days
- Other: _____
- Patient Not Treated

If patient is pregnant:

- Azithromycin 1 gm orally x 1 dose
- Erythromycin 500 mg QID x 7 days
- Amoxicillin 500 mg TID x 7 days

Treatment

Date: ____/____/____

- Ceftriaxone 250 mg IM x 1 dose AND Azithromycin 1 gm orally x 1 dose
- Other: _____
- Patient Not Treated

If patient is pregnant:

- Ceftriaxone 250 mg IM x 1 dose 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: _____
- Patient Not Treated

Was the patient tested for HIV?

No Yes

Date: ____/____/____

EIA WB Rapid Results Pos Neg

Date: ____/____/____

EIA WB Rapid Results Pos Neg

For HIV positive patients not previously reported, please use this form - <http://www.dhhs.nh.gov/dphs/cdcs/documents/adulthivreport.pdf>

Partner Information (all diseases):

Partner Sex: Male Female Both

Number of partners in past 12 months: _____

Partner treated by provider: No Yes

Partner referred for treatment? No Yes

Where? _____

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>

NH RSA 141-C and He-P300 mandate reporting of chlamydia, gonorrhea, and syphilis 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.