

**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.

<b>Patient's Name</b> (Last, First, MI.)		<b>Date of Birth</b>	<b>Age</b>	<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>	<b>Pregnant?</b> N <input type="checkbox"/> Y <input type="checkbox"/> # of weeks _____
<b>Address</b> ( Street, City, State, Zip)			<b>Hispanic Ethnicity</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Race</b> <i>check all that apply</i> W <input type="checkbox"/> B <input type="checkbox"/> AIS <input type="checkbox"/> AI <input type="checkbox"/> PI <input type="checkbox"/>	
<b>Telephone:</b>	<b>Marital Status</b> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>	<b>Employment</b>	<b>Sex of Partners:</b> F <input type="checkbox"/> M <input type="checkbox"/> Both <input type="checkbox"/>		<b>SSN/Medical record No.</b>
<b>Provider Type:</b> <input type="checkbox"/> Private Physician/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 _____					
<b>Exam Date:</b>	<b>Exam Reason:</b> <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				

<b>100 Chancroid</b>  <b>Treatment Date:</b> _____ <b>Treatment Given:</b> <input type="checkbox"/> Azithromycin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Other: _____  <b>Dosage:</b> <input type="checkbox"/> 1 gram <input type="checkbox"/> 250 mg IM <input type="checkbox"/> Other: _____  <input type="checkbox"/> No Treatment Given	<b>200 Chlamydia</b> (Not PID) <input type="checkbox"/> Urine <input type="checkbox"/> Urethral <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervical <input type="checkbox"/> Rectal <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Ophthalmia  <b>Treatment Date:</b> _____ <b>Treatment Given:</b> <input type="checkbox"/> Azithromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____  <b>Dosage:</b> <input type="checkbox"/> 1 gram <input type="checkbox"/> 100 mg BID X 7 days <input type="checkbox"/> Other: _____  <input type="checkbox"/> No Treatment Given	<b>300 Gonorrhea</b> (Not PID) <input type="checkbox"/> Urine <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  <b>Treatment Date:</b> _____ <b>Treatment Given:</b> <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Other: _____  <b>Dosage:</b> <input type="checkbox"/> 250 mg IM <input type="checkbox"/> 1 gram <input type="checkbox"/> Other: _____  <input type="checkbox"/> No Treatment Given	<b>490 Pelvic Inflammatory Disease</b> Disease: <input type="checkbox"/> Chlamydial <input type="checkbox"/> Gonococcal <input type="checkbox"/> Other or Unknown Etiology  <b>Treatment Date:</b> _____ <b>Treatment Given:</b> <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____  <b>Dosage:</b> <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
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<b>600 Lymphogranuloma Venereum (LGV)</b> <input type="checkbox"/>  <b>Treatment Date:</b> _____ <b>Treatment Given:</b> <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____  <b>Dosage:</b> <input type="checkbox"/> 100 mg BID X 21 days <input type="checkbox"/> Other: _____  <input type="checkbox"/> No Treatment Given	<b>700 Syphilis</b> <input type="checkbox"/> Primary (lesions)* <b>report within 24 hrs</b> <input type="checkbox"/> Secondary (symptoms) * <b>report within 24 hrs</b> <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  <b>Treatment Date:</b> _____ <b>Treatment Given:</b> <input type="checkbox"/> Benzathine penicillin G <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____  <b>Dosage:</b> <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	<b>900 HIV/AIDS</b> <input type="checkbox"/> Acute HIV * <b>report within 24 hrs</b> <input type="checkbox"/> HIV Non- AIDS <input type="checkbox"/> HIV with AIDS  Reporting HIV on this document serves as proof of timely report; however, the health department requires additional information on HIV patients.  <b>Reporting Address:</b> <div style="border: 1px dashed black; padding: 10px; text-align: center;">           Dallas County Health and Human            Services, fax numbers:            STI Reporting - 214-819-2825            HIV Reporting - 214-819-6025         </div>
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Reported By: \_\_\_\_\_

Name	Office Address	City	Phone Number
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Use the spaces below to report your patient's sexual or needle sharing partner(s) for confidential notification by a Disease Intervention Specialist (DIS).  
When those listed below are notified of exposure, the DIS will not reveal your patient's identity.

Please consult me or my designated staff before contacting my patient:

<b>Designated Staff Person:</b>	<b>Telephone:</b>	<b>Extension:</b>	<b>Best time to call me or my staff:</b>
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<b>Partner's Name (Last, First, MI.)</b>	Nickname or alias:	Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race	Sex	DOB or approximate age
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<b>Partner's Address (Street, Apartment, City, State)</b>	Telephone: Home: _____ Work: _____	Best time to call or visit partner:
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Date of last exposure to patient: _____	Treatment given: _____
Partner's Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>	Date: _____
Partner's Place of Employment: _____	
Work Hours: _____	

<b>Partner's Name (Last, First, MI.)</b>	Nickname or alias:	Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race	Sex	DOB or approximate age
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Date of last exposure to patient: _____	Treatment given: _____
Partner's Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>	Date: _____
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<b>Partner's Name (Last, First, MI.)</b>	Nickname or alias:	Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race	Sex	DOB or approximate age
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<b>Partner's Address (Street, Apartment, City, State)</b>	Telephone: Home: _____ Work: _____	Best time to call or visit partner:
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Date of last exposure to patient: _____	Treatment given: _____
Partner's Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>	Date: _____
Partner's Place of Employment: _____	
Work Hours: _____	

**◆ ◆ ◆ DO NOT EMAIL THIS FORM ◆ ◆ ◆**