

STI REPORTING FORM

The Privacy Rule in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows for the disclosure of protected health information, without individual client or patient authorization, to public health authorities, who are legally authorized to receive such reports for the purpose of preventing or controlling disease.

Please fax the information to St. Clair County Health Department, Personal Health, Fax # (810) 987-3062

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

Sex: _____ Race: _____ ☐ Hispanic ☐ Non-Hispanic ☐ Arab ☐ Non-Arab

Specimen Submitted By (Physician or Institution): _____

Submitter Address and Phone Number: _____

Date Specimen Taken: _____ Site of Specimen: _____

Laboratory Processing Specimen: _____

Laboratory Tests Performed: _____

Date of Laboratory Results: _____

Results: Chlamydia ☐ Negative ☐ Positive

Gonorrhea ☐ Negative ☐ Positive

Syphilis ☐ Negative

☐ Positive: ☐ RPR 1: _____ ☐ TPPA

☐ USR 1: _____ ☐ FTA

☐ VDRL 1: _____ ☐ IgG

Patient Treated? ☐ Yes ☐ No ☐ Unknown If Yes, Date of Treatment: _____

Specify DRUG/DOSAGE (Check all that apply)

☐ Azithromycin (Zithromax, ZMax, Z-pak) 1gm ☐ Azithromycin (Zithromax, ZMax, Z-pak) Other or Unknown dose

☐ Ceftriaxone (Rochphin) 500mg ☐ Ceftriaxone (Rocephin), Other or Unknown dose ☐ Bicillin 2.4 MUX _____

☐ Doxycycline (Vibramycin) x2 per day x7 days ☐ Doxycycline (Vibramycin) Other or Unknown dose

☐ Other or Unspecified Treatment (specify): _____

Is Patient Pregnant? ☐ Yes, due date: _____ ☐ No ☐ Not Applicable

Method of Case Detection: ☐ Screening ☐ Self-referred ☐ Patient Referred Patient ☐ Health Dept. Referred Partner

Has the Patient Had Sex With a Male in the Past 12 Months? ☐ Yes ☐ No ☐ Refused to Answer ☐ Did Not Ask

Has the Patient Had sex With a Female in the Past 12 Months? ☐ Yes ☐ No ☐ Refused to Answer ☐ Did Not Ask

HIV Status: ☐ Positive ☐ Negative ☐ Equivocal HIV Test ☐ Unknown ☐ Refused to Answer ☐ Did Not Ask

Signature of Person Completing Form: _____ Date: _____



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