

**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.

Patient's Name (Last, First, MI.)		Date of Birth	Age	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Pregnant? N <input type="checkbox"/> Y <input type="checkbox"/> # of weeks
Address (Street, City, State, Zip)			Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race <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"/>	
Telephone:	Marital Status S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>	Employment	Sex of Partners: F <input type="checkbox"/> M <input type="checkbox"/> Both <input type="checkbox"/>		SSN/Medical record No.
Provider Type: <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 _____					
Exam Date:	Exam Reason: <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				
100 Chancroid		200 Chlamydia (Not PID)		300 Gonorrhea (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"/> 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	
Treatment Date: _____		Treatment Date: _____		Treatment Date: _____	
Treatment Given: <input type="checkbox"/> Azithromycin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Other: _____		Treatment Given: <input type="checkbox"/> Azithromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____		Treatment Given: <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Other: _____	
Dosage: <input type="checkbox"/> 1 gram <input type="checkbox"/> 250 mg IM <input type="checkbox"/> Other: _____		Dosage: <input type="checkbox"/> 1 gram <input type="checkbox"/> 100 mg BID X 7 days <input type="checkbox"/> Other: _____		Dosage: <input type="checkbox"/> 250 mg IM <input type="checkbox"/> 1 gram <input type="checkbox"/> Other: _____	
<input type="checkbox"/> No Treatment Given		<input type="checkbox"/> No Treatment Given		<input type="checkbox"/> No Treatment Given	
490 Pelvic Inflammatory Disease Disease: <input type="checkbox"/> Chlamydial <input type="checkbox"/> Gonococcal <input type="checkbox"/> Other or Unknown Etiology					
600 Lymphogranuloma Venereum (LGV) <input type="checkbox"/>		700 Syphilis		900 HIV/AIDS	
		<input type="checkbox"/> Primary (lesions)* report within 24 hrs <input type="checkbox"/> Secondary (symptoms) * report within 24 hrs <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		<input type="checkbox"/> Acute HIV * report within 24 hrs <input type="checkbox"/> HIV Non- AIDS <input type="checkbox"/> HIV with AIDS	
Treatment Date: _____		Treatment Date: _____		Reporting HIV on this document serves as proof of timely report; however, the health department requires additional information on HIV patients.	
Treatment Given: <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____		Treatment Given: <input type="checkbox"/> Benzathine penicillin G <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____		Reporting Address:	
Dosage: <input type="checkbox"/> 100 mg BID X 21 days <input type="checkbox"/> Other: _____		Dosage: <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: _____		GALVESTON COUNTY HEALTH DISTRICT ATTN: EUGENIA M JAMES P.O. BOX 939 LA MARQUE, TX 77568 TEL# 409-765-2528 FAX# 409-765-2510	
<input type="checkbox"/> No Treatment Given		<input type="checkbox"/> No Treatment Given		LOCAL REPORTING AUTHORITY FOR: GALVESTON, CHAMBERS AND BRAZORIA COUNTIES	
Reported By:					
Name		Office Address		City	
				Phone Number	

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES (STD)**

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: <input type="checkbox"/>					
Designated Staff Person:		Telephone:		Extension:	
Best time to call me or my staff:					
Partner's Name (Last, First, MI.)		Nickname or alias:		Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race
				Sex	DOB or approximate age
Partner's Address (Street, Apartment, City, State)			Telephone: Home: _____ Work: _____		Best time to call or visit partner:
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: _____					
Partner's Name (Last, First, MI.)		Nickname or alias:		Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race
				Sex	DOB or approximate age
Partner's Address (Street, Apartment, City, State)			Telephone: Home: _____ Work: _____		Best time to call or visit partner:
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: _____					
Partner's Name (Last, First, MI.)		Nickname or alias:		Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race
				Sex	DOB or approximate age
Partner's Address (Street, Apartment, City, State)			Telephone: Home: _____ Work: _____		Best time to call or visit partner:
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: _____					
Partner's Name (Last, First, MI.)		Nickname or alias:		Hispanic Ethnicity Yes <input type="checkbox"/> No <input type="checkbox"/>	Race
				Sex	DOB or approximate age
Partner's Address (Street, Apartment, City, State)			Telephone: Home: _____ Work: _____		Best time to call or visit partner:
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: _____					

**Mail or fax to local health department or DSHS HIV/STD Control Program.
Go to dshs.texas.gov/hivstd/reporting/ for the address of your
local/regional health authority or call (737) 255-4300.**



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

Texas Department of State
Health Services