SEXUALLY TRANSMITTED DISEASE CONFIDENTIAL CASE REPORT FORM

RHODE ISLAND DEPARTMENT OF HEALTH
CENTER FOR HIV, HEPATITIS, STDs, and TB
3 Capitol Hill, Room 106, Providence, RI 02908
PHONE: (401) 222-2577 | FAX: (401) 222-1105

Mail or fax report form within 4 days of diagnosis.

I. PATIENT INFORMATION:

Last Name	First (full) Name	MI	Date of Birth	Age

Street	Apt #	City/Town	State	Zip	Phone Number : (_ _ _) _ _ _ - _ _ _ _

Sex: ☐ Male ☐ Female | Transgender: ☐ M to F ☐ F to M ☐ Other | Is this patient pregnant? ☐ Yes ☐ No

Ethnic Origin:	Race (check all that apply):	
☐ Hispanic or Latino	☐ American Indian or Alaskan Native	☐ Asian
☐ Not Hispanic or Latino	☐ Black or African American	☐ White
		☐ Native Hawaiian or Pacific Islander

Sex/Gender of partner(s) (Check all that apply): ☐ Refused ☐ Male ☐ Female Transgender: ☐ M to F ☐ F to M ☐Other

Number of partners: _____

II. FACILITY INFORMATION:

Physician or Facility Name	Facility Street Address, City, State, Zip Code
Facility Contact Person for STD Reporting	
Phone Number: (_ _ _) _ _ _ - _ _ _ _	
Fax Number: (_ _ _) _ _ _ - _ _ _ _	

III. HIV TESTING STATUS

Was the patient tested for HIV at this visit? ☐ Yes ☐ No

IV. STD INFORMATION

1. GONORRHEA

Clinical Information (check all that apply):
☐ Asymptomatic
☐ Symptomatic
☐ Pelvic Inflammatory Disease
☐ Referred by partner
☐ Other: _____

Site / Specimen (check all that apply):
☐ Cervix
☐ Pharynx
☐ Rectum
☐ Urethra
☐ Urine
☐ Vagina
☐ Other: _____

Date of Test: __ __ / __ __/ __ __ __ __

Date of Treatment: __ __ / __ __/ __ __ __ __

Treatment:
☐ Ceftriaxone - 250 mg IM in a single dose
PLUS Azithromycin - 1 gram as a single dose
☐ Other Med + Dose: _____

2. CHLAMYDIA

Clinical Information (check all that apply):
☐ Asymptomatic
☐ Symptomatic
☐ Pelvic Inflammatory Disease
☐ Referred by partner
☐ Other: _____

Site / Specimen (check all that apply):
☐ Cervix
☐ Pharynx
☐ Rectum
☐ Urethra
☐ Urine
☐ Vagina
☐ Other: _____

Date of Test: __ __ / __ __/ __ __ __ __

Date of Treatment: __ __ / __ __/ __ __ __ __

Treatment:
☐ Azithromycin – 1 gram as a single dose
☐ Doxycycline – 100 mg 2x/day for 7 days
☐ Other Med + Dose: _____

EXPEDITED PARTNER THERAPY (EPT):
Was EPT offered to the patient? ☐ Yes ☐ No
Was medication prescribed to the patient for their partner (partner does not need to be examined)? ☐ Yes ☐ No

3. SYPHILIS

Clinical Information (check all that apply):
☐ Asymptomatic
☐ Rash
☐ Chancre (sore/lesion)
☐ Condyloma lata
☐ Alopecia
☐ Neurosyphilis
☐ Congenital (infant)
☐ Referred by partner
☐ Other: _____

RPR Titers: _____ Date _ _/_ _/_ _ _ _
_____ Date _ _/_ _/_ _ _ _
FTA Result: _____ Date _ _/_ _/_ _ _ _
_____ Date _ _/_ _/_ _ _ _

Date of Test: __ __ / __ __/ __ __ __ __

Date of Treatment: __ __ / __ __/ __ __ __ __
Medication & Dose:
_____

Last negative syphilis test (if known):
__ __ / __ __/ __ __ __ __

4. OTHER STDs

☐ Chancroid ☐ Granuloma Inguinale ☐ PID (Non-Chlamydial / Non-Gonococcal) ☐ Lymphogranuloma - Venereum (LGV)

The CDC 2015 STD Treatment Guidelines can be viewed at http://www.cdc.gov/std/tg2015/toc.htm

Updated March 7, 2016

2015 CDC SEXUALLY TRANSMITTED DISEASES (STD) TREATMENT SUMMARY GUIDELINES
RHODE ISLAND DEPARTMENT OF HEALTH

These guidelines for treatment of STDs reflect recommendations of the **CDC STD Treatment Guidelines**. The focus is on STDs encountered in outpatient settings and is not an exhaustive list of effective treatments. Please refer to the complete document for more information, or call the STD Program, or see http://health.ri.gov/diseases/sexuallytransmitted/for/providers/. Sexual partner services (identification, notification, risk counseling and referral) for gonorrhea, syphilis and HIV/AIDS will be provided by public health personnel when a case is reported. Contact information for **Partner Services** and to **Report Cases**: **(401) 222-2577. FAX (401) 222-1105. STD Program, Rhode Island Department of Health, Room 106, 3 Capitol Hill, Providence, RI 02908**.

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens contraindicated)
SYPHILIS		
ADULTS PRIMARY, SECONDARY OR EARLY LATENT (<1 YEAR)	• Benzathine penicillin G 2.4 million units IM once	(**For penicillin-allergic non-pregnant patients only**) • Doxycycline 100 mg orally 2 times a day for 14 days ***OR*** • Tetracycline 500 mg orally 4 times a day for 14 days
ADULTS LATE LATENT (>1 YEAR) OR LATENT OF UNKNOWN DURATION	• Benzathine penicillin G 2.4 million units IM for 3 doses at 1 week intervals (total 7.2 million units)	(**For penicillin-allergic non-pregnant patients only**) • Doxycycline 100 mg orally 2 times a day for 28 days ***OR*** • Tetracycline 500 mg orally 4 times a day for 28 days
All Suspect Syphilis Cases: Call the STD Registry at (401) 222-2577 for past titers and treatment. **NEUROSYPHILIS including OCULAR SYPHILIS**	• Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion, for 10-14 days[1]	• Procaine penicillin G 2.4 million units IM once daily **PLUS** probenecid 500 mg orally 4 times a day, both for 10-14 days
CHILDREN PRIMARY, SECONDARY OR EARLY LATENT (<1 YEAR)	• Benzathine penicillin G 50,000 units/kg IM once, up to adult dose of 2.4 million units	No specific alternative regimens exist.
CHILDREN LATE LATENT (>1 YEAR) OR LATENT OF UNKNOWN DURATION	• Benzathine penicillin G 50,000 units/kg IM (up to adult dose of 2.4 million units) for 3 doses at 1 week intervals (up to total adult dose of 7.2 million units)	
CONGENITAL SYPHILIS	See complete CDC guidelines.	
HIV INFECTION	Same stage-specific recommendations as for HIV-negative persons.	
PREGNANCY	Penicillin is the only recommended treatment for syphilis during pregnancy. Women who are allergic should be desensitized and treated with penicillin. Treatment is the same as in non-pregnant patients for each stage of syphilis.[2]	
GONOCOCCAL INFECTIONS		
ADULTS, ADOLESCENTS AND CHILDREN >45 KG PHARYNGEAL, UROGENITAL, RECTAL ***Partner Management:*** Empiric treatment of all sexual contacts during the 60 days preceding symptom onset or, if asymptomatic, date of diagnosis.	• Ceftriaxone 250 mg IM once **PLUS**[3] • Azithromycin 1 g orally once	***Note:*** **Use of an alternative regimen for pharyngeal gonorrhea should be followed by a test-of-cure 14 days after treatment.**[4] **For urogenital or rectal infections ONLY, and ONLY if ceftriaxone is *not* available:** • Cefixime 400mg orally once **PLUS**[3] • Azithromycin 1 g orally once **OR in case of azithromycin allergy** • Doxycycline 100 mg orally 2 times a day for 7 days **For azithromycin allergy:** ♦ Ceftriaxone 250 mg IM once **PLUS**[3] ♦ Doxycycline 100 mg orally 2 times a day for 7 days **For cephalosporin allergy or IgE-mediated penicillin allergy:** ♦ Gemifloxacin 320 mg orally once ***OR*** ♦ Gentamicin 240 mg IM once **PLUS**[3] ♦ Azithromycin 2 g orally once
ADULTS AND ADOLESCENTS CONJUNCTIVAL	• Ceftriaxone 1 g IM once **PLUS**[3] ♦ Azithromycin 1 g orally once, plus consider lavage of infected eye with saline solution once	No specific alternative regimens exist.
CHILDREN ≤45 KG	• Ceftriaxone 25-50 mg/kg IV or IM once (max 250 mg)	
NEONATES OPHTHALMIA NEONATORUM INFANTS BORN TO INFECTED MOTHERS	• Ceftriaxone 25-50 mg/kg IV or IM once (max 250 mg)	
CHLAMYDIAL INFECTIONS		
ADULTS AND CHILDREN AGED ≥8 YEARS	• Azithromycin 1 g orally once ***OR*** • Doxycycline[5] 100 mg orally 2 times a day for 7 days	• Erythromycin base 500 mg orally 4 times a day for 7 days[6] ***OR*** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days[6] ***OR*** • Levofloxacin[7] 500 mg orally once a day for 7 days ***OR*** • Ofloxacin[7] 300 mg orally 2 times a day for 7 days
CHILDREN ≥45 KG BUT AGED <8 YEARS	• Azithromycin 1 g orally once	No specific alternative regimens exist.
CHILDREN <45 KG AND NEONATES	• Erythromycin base or ethylsuccinate 50 mg/kg/day orally divided into four doses daily for 14 days[8]	**For ophthalmia neonatorum:** ♦ Azithromycin 20 mg/kg/day orally once a day for 3 days[9]
Partner Management: Expedited partner therapy (EPT) is allowed in Rhode Island for treatment of partners of patients infected with chlamydia. For more information, go to www.health.ri.gov/diseases/sexuallytransmitted/for/providers/. **PREGNANCY**	• Azithromycin 1 g orally once	♦ Amoxicillin 500 mg orally 3 times a day for 7 days ***OR*** • Erythromycin base 500 mg orally 4 times a day for 7 days (or 250 mg orally 4 times a day for 14 days) ***OR*** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days (or 400 mg orally 4 times a day for 14 days)
NONGONOCOCCAL URETHRITIS		
ADULT MALES	• Azithromycin 1 g orally once[10] ***OR*** • Doxycycline[5] 100 mg orally 2 times a day for 7 days	• Erythromycin base 500 mg orally 4 times a day for 7 days[6] ***OR*** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days[6] ***OR*** • Levofloxacin[7] 500 mg orally once a day for 7 days ***OR*** • Ofloxacin[7] 300 mg orally 2 times a day for 7 days
EPIDIDYMITIS[11]		
LIKELY DUE TO CHLAMYDIA AND GONORRHEA	• Ceftriaxone 250 mg IM once **PLUS** • Doxycycline[5] 100 mg orally 2 times a day for 10 days	No specific alternative regimens exist.
LIKELY DUE TO CHLAMYDIA AND GONORRHEA AND ENTERIC ORGANISMS (MEN WHO PRACTICE INSERTIVE ANAL SEX)	♦ Ceftriaxone 250 mg IM once **PLUS** ♦ Levofloxacin[7] 500 mg orally once a day for 10 days ***OR*** ♦ Ofloxacin[7] 300 mg orally twice a day for 10 days	No specific alternative regimens exist.
PELVIC INFLAMMATORY DISEASE (outpatient management)		
ADULT FEMALES	• Ceftriaxone 250 mg IM once ***OR*** • Cefoxitin 2 g IM once **plus** probenecid 1 g orally once ***OR*** • Other parenteral third generation cephalosporin (e.g., ceftizoxime or cefotaxime) **PLUS** • Doxycycline[5] 100 mg orally 2 times a day for 14 days **WITH OR WITHOUT** • Metronidazole[12] 500 mg orally twice a day for 14 days	See complete CDC guidelines for alternatives.

♦ Indicates revision from previous STD Treatment Guidelines

[1] Some specialists recommend benzathine penicillin G 2.4 million units IM weekly for up to 3 weeks after completion of neurosyphilis (including ocular syphilis) treatment.
[2] Tetracycline/doxycycline contraindicated; erythromycin not recommended because it does not reliably cure an infected fetus; data insufficient to recommend azithromycin or ceftriaxone.
[3] Dual therapy for gonococcal infection recommended for all patients with gonorrhea regardless of chlamydia test results.
[4] Test of cure no longer necessary in cases of uncomplicated urogenital or rectal gonorrhea treated with recommended or alternative regimens. Test-of-cure for gonorrhea should be performed with culture or with nucleic acid amplification (NAAT) if culture not available. If NAAT positive, confirmatory culture recommended. If treatment failure suspected: culture, perform antimicrobial susceptibility testing, notify and consult with the state health department, and/or consult with an infectious disease specialist, an STD/HIV Prevention Training Center (www.nnptc.org), or CDC.
[5] Doxycycline not recommended during pregnancy, lactation, or for children <8 years of age.
[6] If patient cannot tolerate high dose erythromycin schedules, change to lower dose for longer (see under pregnancy alternatives).
[7] Quinolones not recommended for use in patients <18 years of age, and contraindicated in pregnant women.
[8] Efficacy of treating neonatal chlamydial conjunctivitis and pneumonia is about 80%. A second course of therapy may be required. An association between oral erythromycin and infantile hypertrophic pyloric stenosis (IHPS) has been reported in infants aged <6 weeks. See complete CDC guidelines for more information.
[9] Data on efficacy of azithromycin for ophthalmia neonatorum limited, so follow-up recommended to assess response. An association between oral azithromycin and infantile hypertrophic pyloric stenosis (IHPS) has been reported in infants aged < 6 weeks. See complete CDC guidelines for more information.
[10] Infections with *M. genitalium* may respond better to azithromycin, although azithromycin efficacy may be declining.
[11] Given increase in quinolone resistant gonorrhea, use of ofloxacin or levofloxacin alone recommended only if infection more likely caused only by enteric gram-negative organisms and gonorrhea has been ruled out.
[12] Consuming alcohol should be avoided during treatment with metronidazole and for 24 hours thereafter. Multiple studies and meta-analyses have *not* demonstrated an association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women administered metronidazole, withholding breastfeeding during treatment and for 12–24 hours after last dose will reduce exposure of infant to metronidazole.