

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

To: Washoe County Health District Sexual Health program  
Confidential Fax (775) 328-3764

Facility: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Sender: \_\_\_\_\_

Re: SEXUALLY TRANSMITTED DISEASES / HIV \_\_\_\_\_ Number of Pages Faxed

**\*\* Fax fully completed form, with client's face sheet, provider notes and lab results \*\***

\*\*Additional information may be requested as needed to complete the investigation (per NAC 441A.230). \*\*

CONFIDENTIAL CASE REPORT— SEXUALLY TRANSMITTED DISEASES / HIV					
<b>Patient's Last Name:</b>		<b>First:</b>	<b>Initial:</b>	<b>DOB:</b> ____/____/____	<b>Age:</b>
<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Race (Please ✓ one):</b> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	<b>Ethnicity (✓ one):</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	<b>Address:</b>		
<b>Pregnant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No # wks: _____	<b>Marital Status:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Provider's Name:</b>			<b>Provider's Phone #:</b>		
<b>Disease:</b> <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV				<b>Specimen Collection Date:</b> ____/____/____	
<b>Date of Diagnosis:</b> _____					
<b>Treatment:</b> <input type="checkbox"/> Azithromycin 1g <input type="checkbox"/> Ceftriaxone/Rocephin 250 mg IM <input type="checkbox"/> L-A Bicillin 2.4 mu IM <input type="checkbox"/> Other _____			<b>Tx Date:</b> ____/____/____	<b>Tx administered:</b> Dr.'s office/Prescription	
<b>Please complete the following for ALL cases</b>					
<b>Sex with:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both		<b>Partner info:</b> Name: _____ DOB: _____ Age: _____			
<b>HIV status:</b> <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk		Tel#: _____ Last sex when? _____			
<b>Date last tested:</b> _____		<input type="checkbox"/> Steady <input type="checkbox"/> 1x-only <input type="checkbox"/> on/off # Partners in last 3 mos?__			
<b>If + In Care?      Where?</b>		<input type="checkbox"/> Partner F/U: <input type="checkbox"/> Hopes <input type="checkbox"/> HD <input type="checkbox"/> PMD <input type="checkbox"/> Other _____ <input type="checkbox"/> Epi-treated?			
<b>Please complete the following if reporting Syphilis</b>					
Symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes-how long? _____			<b>Provider Diagnosis:</b>		
If Yes, <input type="checkbox"/> Chancre <input type="checkbox"/> Rash <input type="checkbox"/> Other _____			<input type="checkbox"/> Primary Syphilis <input type="checkbox"/> Secondary Syphilis		
Where? <input type="checkbox"/> Genital <input type="checkbox"/> Oral <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Body			<input type="checkbox"/> Early Latent <input type="checkbox"/> Late Latent		
Neurological Involvement? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe:			<input type="checkbox"/> Old previously treated		
Previous Hx of Syphilis? <input type="checkbox"/> No <input type="checkbox"/> Yes			<input type="checkbox"/> BFP – (False Positive) <i>Please include copy of any NR confirmatory tests</i>		
If Yes, City/State treated _____ Year _____			<b>Plan:</b> <input type="checkbox"/> Treated on day of visit.		
Treated with: <input type="checkbox"/> Shots <input type="checkbox"/> Pills			<input type="checkbox"/> Not treated yet. Appt on: _____		
Previous Syphilis Test? <input type="checkbox"/> No <input type="checkbox"/> Yes			<input type="checkbox"/> Previously treated. Repeat titer _____		
If Yes, Date: _____ Results: RPR <input type="checkbox"/> Negative <input type="checkbox"/> Positive			<input type="checkbox"/> Unable to contact. Reason: _____		
If positive, RPR titer: _____ FTA/TPPA: _____					

**Note: To speak with the on-duty Disease Intervention Specialist, contact (775) 328-6161.  
For HIV Disease Investigators, contact (775) 328-6142, (775) 328-6147, or (775) 328-6156.**