STD Surveillance
Florida Department of Health in Seminole County

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www.seminolecohealth.com

FLORIDA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES

Patient Name:
DOB:
SS#:
Address:
Phone:
Race: **White**___ **Black**___ **Other**___ **AM Indian/Alaskan**___
Asian/Pacific Islander___ **Hispanic**___ **Non-Hispanic** ___

Female _____ **Male** _____
Not Pregnant_____ **Pregnant** _____
Pregnancy due date_____

CHLAMYDIA	GONORRHEA	SYPHILIS	OTHER
___Opthalmia ___Oral/Pharyngeal ___Pelvic Inflammatory Disease (PID) ___Pneumonia ___Uncomplicated	___Disseminated Gonococcal ___Opthalmia ___Oral/Pharyngeal ___Other resistant strain ___Pelvic Inflammatory Disease ___Penicillinase-Producing Neisseria Gonorrhea(PPNG) ___Rectal ___Uncomplicated	___RPR 1:____ **Types of Confirmatory test** ___TP-PA positive ___FTA positive ___IgG EIA positive ___MHA-TP **Diagnosis** ___ Primary ___ Secondary ___ Early Latent (< l yr) ___Late Latent ___Tertiary - Cardio ___ Congenital	___Chancroid ___Granuloma Inguinal ___**Herpes Simplex** Only report through age 11 ___**Human Papillomarvirus** Only report through age 11 ___Lymphogranuloma Venereum ___Other (specify)
Collection date	Collection date	Collection date	Collection date
Reporting laboratory	Reporting laboratory	Reporting laboratory	Reporting laboratory
Treatment date _____ *** CDC Recommended Regimen** **___Azithromycin 1 gm*** **___Doxycycline 100 mg BID x 7 Days**☐ ___Levofloxacin 500 mg x 7 Days ___Ofloxacin 300 mg BID x 7 Days ___Amoxicillin 500 mg TID x 7 Days ___Erythromycin base 500 QID x 7 Days ***IF PREGNANT*** **___Azithromycin 1 gm**☐ ___Erythromycin base 500 QID x 7 days ___Amoxicillin 500 TID x 7 Days **Any tx used other than recommended treatment will need a TOC 3 weeks after completion of therapy. TOC less than 3 wks could yield false positive results**	**Treatment date**_____ ***CDC Recommended Regimen** **Uncomplicated gonococcal infections of the cervix, urethra, rectum, pharynx, and pregnant females:** **___Ceftriaxone 250 mg IM plus AZ 1 gm preferred*** **or** ___Ceftriaxone 250 mg IM plus Doxy 100 mg BID x 7 days (Not for Pregnant females) ***ONLY IF*** *The pt has severe cephalosporin allergy:* ___ *AZ 2 gm in a single oral dose* *_AND TOC in 1 week*	**Treatment dates:** 2.4 BIC #1_____ 2.4 BIC #2_____ 2.4 BIC #3_____ ___Doxycycline 100 BID x 14 days **Date**_____ ___Doxycycline 100 QID x 28 days **Date**_____ **COMPLETE, PRINT AND FAX THIS FORM TO:** **(407) 665-3295**	**CALL TO REPORT:** **HIV/AIDS** (407) 858-1400 X1297 **STD** (407) 665-3285 or (407) 665-3286

Physician/Healthcare Professional Name_____

Practice Name_____

Address_____ **Phone(** **)** _____