SEXUALLY TRANSMITTED DISEASE CONFIDENTIAL CASE REPORT

STD-23 NEW 2/90

☐ **NOTE:** Check this box to request additional forms

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
STD CONTROL PROGRAM
410 Capitol Avenue, MS #11STD, Hartford, CT 06134

PATIENT INFORMATION

NAME *(Last)* *(First)* *(M.I.)* | HOME PHONE NO. ( ) - | OTHER NO. ( ) -

ADDRESS *(No. and Street)* *(City or Town)* *(State)* *(Zip Code)*

SEX ☐ M ☐ F | PREGNANT? ☐ Y ☐ N | AGE or DATE OF BIRTH | MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ UNKNOWN

RACE ☐ WHITE ☐ BLACK or AFRICAN AMERICAN ☐ AMERICAN INDIAN or ALASKA NATIVE ☐ ASIAN ☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER ☐ UNKNOWN | ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC ☐ UNKNOWN

SEXUAL ORIENTATION ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL ☐ UNKNOWN

DISEASE INFORMATION

☐ GONORRHEA or ☐ CHLAMYDIA

- ☐ SYMPTOMATIC UNCOMPLICATED
- ☐ ASYMPTOMATIC
- ☐ PID
- ☐ OTHER *(Please specify)* _____

SYPHILIS

- ☐ PRIMARY (Chancre Present)
- ☐ SECONDARY (Rash, Lesions, etc.)
- ☐ EARLY LATENT - NO Sx (Duration < 1 Yr.)
- ☐ LATE LATENT - NO Sx (Duration > 1 Yr.)
- ☐ LATE (CNS, CV, Benign)
- ☐ CONGENITAL

PARTNER NOTIFICATION SERVICES

Providers treating STD's are expected to counsel patients in prevention and identify and refer partners to medical care for examination and treatment.

- ☐ Partners referred for exam and treatment by provider
- ☐ Provider requesting assistance with partner notification from state health department

OTHER STD

- ☐ NEONATAL HERPES
- ☐ CHANCROID
- ☐ OTHER/*(REPORT OPTIONAL)* ***SPECIFY:*** _____

TREATMENT INFORMATION

TREATMENT DATE *(Mo., Day, Yr.)* ☐ NOT TREATED

SPECIFY ANTIBIOTIC AND DOSAGE:

DIAGNOSTIC INFORMATION

TEST DATE *(Mo., Day, Yr.)* ☐ LABORATORY CONFIRMED ☐ CLINICAL DIAGNOSIS NO LAB. CONFIRMATION

REPORTING LABORATORY

GIVE RESULTS OR ATTACH LAB REPORT OF SIGNIFICANT FINDING.

DATE OF REPORT *(Mo.)* *(Day)* *(Yr.)*

ATTENDING PHYSICIAN: | ADDRESS | PHONE NO.

COMPLETE THE FOLLOWING INFORMATION IF REPORTED FROM HOSP/INST.

NAME OF PERSON REPORTING, *(If different than above)* | PHONE NO. | MEDICAL RECORD NO.

NAME OF HOSP/INST. | ☐ IP ☐ OPC _____ ☐ ER/PCU ☐ OB/GYN FAMILY PLANNING | **HEALTH DEPT. USE**

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