

# STD-23 Report Form Instructions

**IMPORTANT: Copy the form to your computer.**

Click in the first field (Name – Last) to begin data entry. Use the tab key to move to the next field or left click with the mouse in the field needed to continue entering information. Select boxes by left clicking in the box.

STD\_23 Entry Form\_2010.pdf - Adobe Acrobat Professional

Please fill out the following form. If you are a form author, choose Distribute Form in the Forms menu to send it to your recipients. Highlight Fields

**SEXUALLY TRANSMITTED DISEASE  
CONFIDENTIAL CASE REPORT**  
STD-23 NEW 2/90

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

**PATIENT INFORMATION**

NOTE: Check this box to request additional forms

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

ADDRESS (Street or PO Box)  (City or town)  (State)  (Zip Code)

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 (Chancere Present)  LATE LATENT - NO Sx (Duration > 1 Yr.)  
 SECONDARY (Rash, Lesions, etc.)  LATE (CNS, CV, Benign)  
 EARLY LATENT - NO Sx (Duration < 1 Yr.)  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**

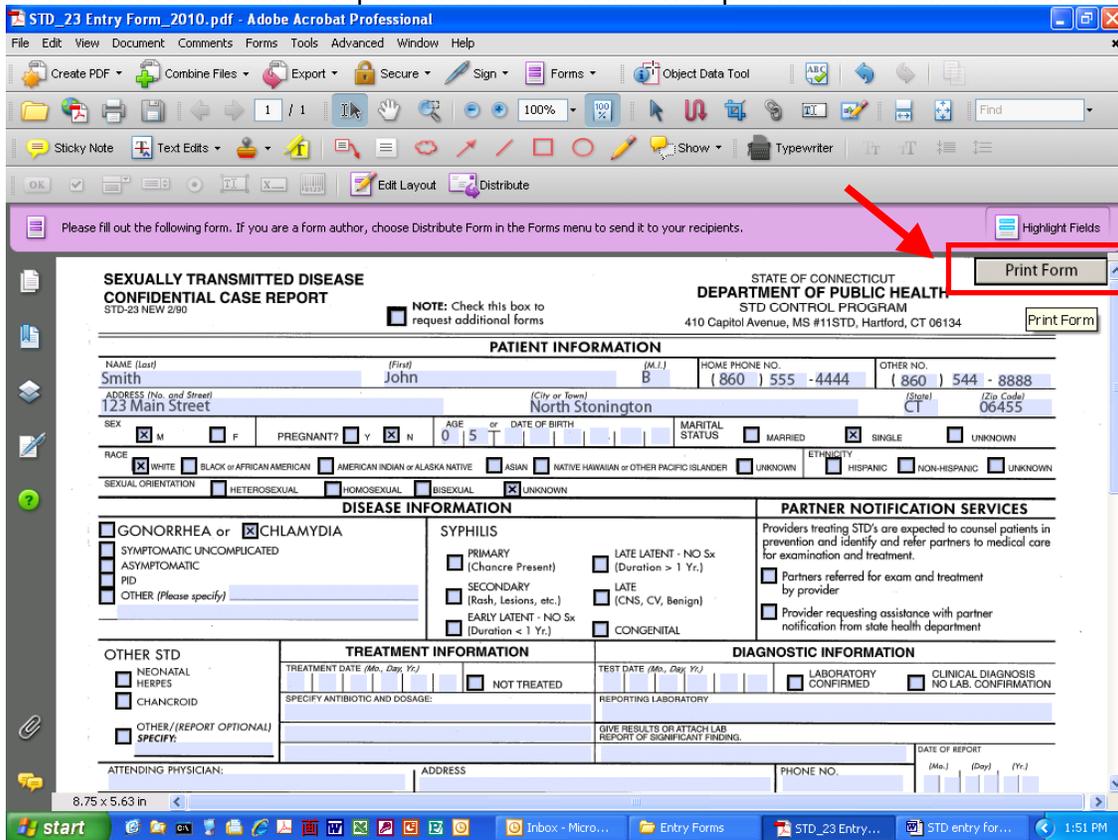
TEST DATE (Mo., Day, Yr.)  LABORATORY CONFIRMED  CLINICAL DIAGNOSIS NO LAB. CONFIRMATION

REPORTING LABORATORY

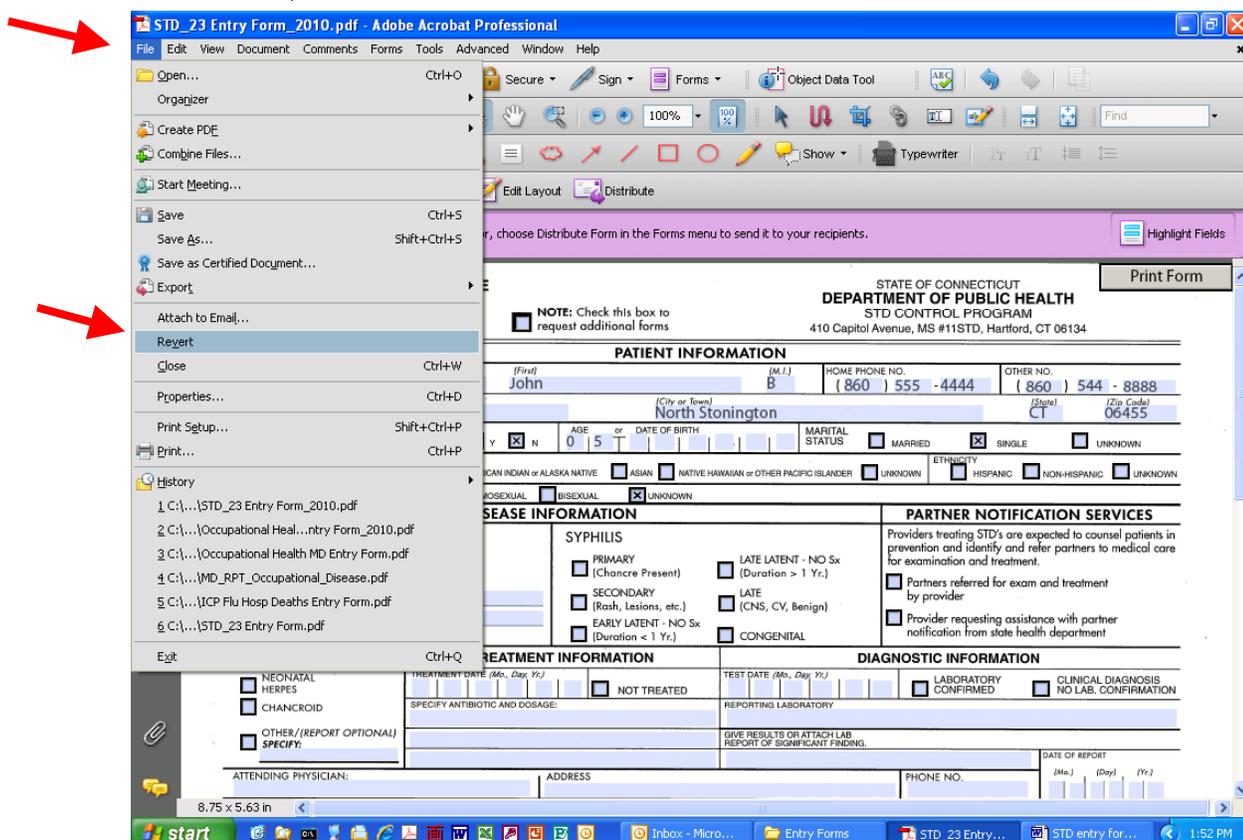
GIVE RESULTS OR ATTACH LAB REPORT OF SIGNIFICANT FINDING.

ATTENDING PHYSICIAN:  ADDRESS  PHONE NO.  DATE OF REPORT (Mo.)  (Day)  (Yr.)

Data can not be saved, forms must be printed. When the form is completed click the “Print Form” button in the upper right corner of the form. Be sure to mail or fax one copy to the **State of Connecticut, Department of Public Health, 410 Capitol Avenue MS#11STD, Hartford, CT, 06134-0308 (fax # 860-509-7910)**, send one copy to the local health director of the patient’s town of residence, and keep one copy in the patient’s clinic record. Mailed reports must be sent in envelopes marked “Confidential”.



To clear all information, click on “File” and select “Revert”.



For more information call: the Department of Public Health, STD Control Program at 860-509-7920.