INDIANA CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE (STD) REPORTING

State Form 56459 (1-18)

Indiana State Department of Health

PATIENT INFORMATION

Legal Last Name: ______________________ **Legal First Name:** ______________________ **MI:** ____

Preferred Name (*if different than legal name*):______________________ **Date of Birth:** ____/_____/______

Address ***(number and street)*:**____

City/State/ZIP:______________________________ **County:** ______________________

Telephone: ______________________ ☐ Home ☐ Work ☐ Cell

Sex: ☐ Male ☐ Female ☐ Transgender: Male to Female ☐ Transgender: Female to Male ☐ Other **Pregnant**: ☐ Yes ☐ No

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ Other ☐ Multiracial ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Health Insurance:** ☐ Yes ☐ No **Marital Status:** ☐ Single ☐ Married

******For reports of positive chlamydia, gonorrhea, and syphilis cases only.******

Check all that apply: ☐ **CHLAMYDIA** ☐ **GONORRHEA:**

☐ Pelvic Inflammatory Disease **Specimen Source:** **Collection Date:** ______/______/______

☐ Cervix ☐ Patient-collected vaginal **Test Type:** ______________________

☐ Urethral ☐ Urine ☐ Rectal ☐ Pharyngeal

Treatment:

☐ Prescribed ☐ Administered ☐ Patient Not Treated ☐ Patient Not Informed of Result **Date:** ______/______/______

Treatment Regimen *(including dosage)***:**

____

Does patient have sex with: ☐ Men ☐ Women ☐ Both ☐ Unknown

Were patient's partners notified of exposure? ☐ Yes, by our office. ☐ Yes, patient notified partners. ☐ No ☐ Unknown

Treatment given for patient's partners? ☐ Yes, extra medication given for ___ (#) partners. ☐ Yes, prescription written for ___ (#) partners. ☐ No

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SYPHILIS: ***Please report all positive test results and negative reflex test results.***

☐ Primary ☐ Secondary ☐ Early (less than 12 months duration) ☐ Late (greater than 12 months duration) ☐ Congenital ☐ Unknown

Collection date: ______/______/______ **Symptoms:** ______________________

Onset Date: ______/______/______ ☐ Neurologic symptoms? ☐ Ocular symptoms? ☐ Otic symptoms?

Non-Treponemal Tests: **Treponemal Tests:**

☐ RPR ☐ VDRL ☐ CSF-VDRL EIA IgG: ☐ Positive ☐ Negative FTA: ☐ Positive ☐ Negative

☐ Positive ☐ Negative Titer: 1:___ TPPA: ☐ Positive ☐ Negative Other *(specify)*:____________ Result: _____________

Treatment:

☐ Prescribed ☐ Administered ☐ Patient Not Treated ☐ Patient Not Informed of Result **Date:** ______/______/______

Treatment Regimen *(including dosage)***:**

____

Does patient have sex with: ☐ Men ☐ Women ☐ Both ☐ Unknown

Were patient's partners notified of exposure? ☐ Yes, by our office. ☐ Yes, patient notified partners. ☐ No ☐ Unknown

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Ordering Provider: ______________________ **Provider Facility:** ______________________ **Telephone**:______________

Person Completing Form: ______________________ **Date of Report:** ______/______/______

Name: ____

Fax: ____

Contact Telephone: ____

All reports of sexually transmitted disease must be made within seventy-two (72) hours of diagnosis. Please fax form to district STD reporting facility. For a list of fax numbers by county, please visit http://www.in.gov/isdh/17440.htm. Contains confidential information per 410 IAC 1-2.5-78.