Utah Department of Health & Human Services

IN PARTNERSHIP WITH UTAH'S PUBLIC HEALTH DEPARTMENTS

Phone: ***1 (888) 374-8824*** *Confidential Fax:* ***(801) 538-9923*** *Email:* **reporting@utah.gov**

Chlamydia and gonorrhea case report form

Instructions

Complete all sections of this form using available data and fax or email the completed form to Utah public health. As chlamydia and gonorrhea are reportable diseases, client consent to release this information to Utah public health is* ***not required*** *and disease reporting is mandatory per Utah State Health Code 26B.*

**case reports submitted via email need to be sent securely via an encryption service such as Virtru.*

Demographic information

Last name: First name: MI:

Address: City:

State: County: ZIP:

Phone #1: Phone #2: Phone #3:

Date of birth: ____/____/____ Age: Birth sex: *(check one)* ☐ M ☐ F

Current gender: *(check one)* ☐ M ☐ F ☐ FTM ☐ MTF ☐ Non-binary ☐ Other, specify:_____

Race: *(Check all that apply)*
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Unknown ☐ Other, specify: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Primary language: ☐ English ☐ Spanish ☐ Other, specify: _____

Treatment information

See CDC STI Treatment Guidelines, 2021 for complete treatment guidelines including alternate treatment regimens. Please note that these guidelines were updated on July 22, 2021

Chlamydia treatment

☐ Doxycycline 100 mg orally BID x 7 days Treatment date: ____/____/____
☐ Azithromycin 1 g orally in a single dose
☐ Other, specify: _____

Gonorrhea treatment

☐ Ceftriaxone 500 mg IM in a single dose Treatment date: ____/____/____
☐ Cefixime 800 mg orally in a single dose*
☐ Other, specify: _____

Patient name: _____

Laboratory information

Attach a copy of the lab results

Reporting

Reporter's name: _____ Phone number: _____

Reporter's agency: _____ Date reported to public health: ____/____/____

Clinical information

Clinician name: _____ Clinician phone #: (_____) _____ - _____

Pregnant: ☐ Yes ☐ No ☐ Unknown ☐ N/A

Date of last HIV test: ____/____/____ Test result: ☐ Pos. ☐ Neg. ☐ Equivocal ☐ Unknown

Is the patient MSM (a man who has sex with men): ☐ Yes ☐ No ☐ Unknown ☐ N/A

Expedited partner therapy

Expedited partner therapy (EPT) enables providers to treat the sexual partners of patients diagnosed with chlamydia or gonorrhea by giving a prescription or medication to the patient to take to their partner(s).

**EPT is not recommended for partners who have had an oral exposure to gonorrhea, as oral treatment is less effective at eradicating pharyngeal gonorrhea than IM ceftriaxone. Clinicians should use shared decision-making when considering offering EPT to MSM due to high rates of comorbidities in this population.*

Was EPT provided to any of the patient's partners? ☐ Yes ☐ No

How many partners were treated with EPT? ____

Record the treatment given in the partners section. For unknown partners, put first and last names as unknown and fill in any information about them you may have (e.g., phone number).

Contact management

Complete the following information for all partners the patient has had sexual contact with in the last 90 days.

Name: _____ Sex: ☐ M ☐ F DOB / age: _____

Address: _____ Phone: (____) _____ - _____

Treatment provided: _____ Was this treatment EPT? ☐ Yes ☐ No

Date of last sexual encounter: ____/____/____

Patient name: ____________________________

Name: ______________________________________ Sex: ☐ M ☐ F DOB / age: ______________

Address: ____ Phone: (____) ______ - ____________

Treatment provided: ___________________________________ Was this treatment EPT? ☐ Yes ☐ No

Date of last sexual encounter: ____/____/____

Name: ______________________________________ Sex: ☐ M ☐ F DOB / age: ______________

Address: ____ Phone: (____) ______ - ____________

Treatment provided: ___________________________________ Was this treatment EPT? ☐ Yes ☐ No

Date of last sexual encounter: ____/____/____

Name: ______________________________________ Sex: ☐ M ☐ F DOB / age: ______________

Address: ____ Phone: (____) ______ - ____________

Treatment provided: ___________________________________ Was this treatment EPT? ☐ Yes ☐ No

Date of last sexual encounter: ____/____/____

Name: ______________________________________ Sex: ☐ M ☐ F DOB / age: ______________

Address: ____ Phone: (____) ______ - ____________

Treatment provided: ___________________________________ Was this treatment EPT? ☐ Yes ☐ No

Date of last sexual encounter: ____/____/____

Name: ______________________________________ Sex: ☐ M ☐ F DOB / age: ______________

Address: ____ Phone: (____) ______ - ____________

Treatment provided: ___________________________________ Was this treatment EPT? ☐ Yes ☐ No

Date of last sexual encounter: ____/____/____