Utah Department of Health and Human Services
288 North 1460 West
P.O. Box 142104
Phone: ***(801) 538-6191*** *Confidential Fax* ***(801) 538-9923***

IN PARTNERSHIP WITH
UTAH'S **PUBLIC HEALTH** DEPARTMENTS

Chlamydia and Gonorrhea

CONFIDENTIAL CASE REPORT

INSTRUCTIONS

Please complete all sections of this form utilizing available data and fax 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 26-6-6.

DEMOGRAPHIC INFORMATION

Last Name: First Name: MI:

Address: City: State:

County: Zip: Date of birth: _____/_____/_____ Age:

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

Birth Sex: *(Check one)* □ Male □ Female Current Gender: *(Check one)* □ Male □ Female

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: ______________________________

LABORATORY INFORMATION

Please attach a copy of the lab results

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

Treatment: □ **Doxycycline 100 mg orally BID x 7 days** Treatment Date: _____/_____/_____
□ Azithromycin 1 g orally in a single dose
□ Other, specify: ______________________________

Treatment: □ **Ceftriaxone 500 mg IM in a single dose** Treatment Date: _____/_____/_____
□ Cefixime 800 mg orally in a single dose
□ Other, specify: ______________________________

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: _____/_____/_____ HIV Status: □ Pos. □ Neg. □ Equivocal □ Unknown

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

CONTACT MANAGEMENT

If known, please 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: ( ) _______ - _____________

Other contact info: ____

Date of last sexual encounter: _____/_____/_____

Name: ____ Sex: □ M □ F DOB / AGE: _______________

Address: ____ Phone: ( ) _______ - _____________

Other contact info: ____

Date of last sexual encounter: _____/_____/_____

Name: ____ Sex: □ M □ F DOB / AGE: _______________

Address: ____ Phone: ( ) _______ - _____________

Other contact info: ____

Date of last sexual encounter: _____/_____/_____