



# CONFIDENTIAL HIV/STD REPORT FORM

Section of Epidemiology | HIV/STD Program  
Phone (907) 269-8000 | Confidential Fax (907) 561-4239

Cases are required to be reported within 2 working days (7 AAC 27.005 & 7 AAC 27.007)



PATIENT INFORMATION					
LAST NAME		FIRST NAME, MI		PREFERRED NAME	
ADDRESS		CITY		MO	DAY
TELEPHONE		EMAIL		DATE OF BIRTH	
SEX ASSIGNED AT BIRTH		GENDER IDENTITY		ENGLISH SPEAKING?	
GENDER OF SEX PARTNERS		HIV STATUS		CURRENTLY PREGNANT?	
REASON FOR EXAM		GONORRHEA (lab confirmed)		SYPHILIS (suspected or probable)	
CHLAMYDIA (lab confirmed)		GONORRHEA (lab confirmed)		SYPHILIS (suspected or probable)	
PARTNER MANAGEMENT		GONORRHEA (lab confirmed)		SYPHILIS (suspected or probable)	
REPORTING CLINIC INFORMATION		GONORRHEA (lab confirmed)		SYPHILIS (suspected or probable)	

Thank you for reporting. All information is managed with the strictest confidentiality.

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