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	DATE OF BIRTH MO / DAY / YR

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE	EMAIL	ENGLISH SPEAKING?	CURRENTLY PREGNANT?
		○ Yes ○ No (Lang. _____)	○ Yes ____ Weeks ○ No ○ Unknown

SEX ASSIGNED AT BIRTH
○ Male ○ Female ○ Intersex ○ Refused

GENDER IDENTITY
○ Male ○ Female ○ Nonbinary/Genderqueer ○ Transgender MTF ○ Transgender FTM ○ Other:_____

ETHNICITY
○ Hispanic ○ Non-Hispanic ○ Unknown

RACE (check all that apply)
☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Other ☐ Unknown

REASON FOR EXAM
○ Referred by Partner ○ DIS Referral ○ Symptomatic ○ Routine Exam (Asymptomatic) ○ Prenatal Exam

GENDER OF SEX PARTNERS (check all that apply)
☐ Male ☐ Female ☐ Nonbinary / Genderqueer ☐ Other: _____ ☐ Transgender MTF ☐ Transgender FTM ☐ Unknown

HIV STATUS
○ Preliminary (pending confirmation) ○ New diagnosis (lab confirmed) ○ Previous diagnosis ○ Negative (lab confirmed) ○ Did not test/Unknown status

CURRENTLY ON PrEP?
○ Yes ○ No ○ Unknown

DIAGNOSIS - DISEASE

GONORRHEA (lab confirmed)

DIAGNOSIS (check one)
○ Asymptomatic ○ Symptomatic, Uncomplicated ○ Ophthalmic ○ Disseminated ○ Pelvic Inflammatory Disease ○ Other Complications _____

Specimen Date _____

Laboratory _____

SITES (check all sites that tested positive)
☐ Eyes ☐ Pharynx ☐ Urethra ☐ Vagina ☐ Cervix ☐ Urine ☐ Rectum ☐ Other _____

TREATMENT (see CDC guidelines)
Date Administered _____
☐ Ceftriaxone ☐ 500 mg IM ☐ 1 g IM
☐ Gentamicin 240 mg IM + Azithromycin 2 g PO

Date Prescribed _____
☐ Azithromycin ☐ 1 g PO ☐ 2 g PO
☐ Cefixime 800 mg PO
☐ Doxycycline 100 mg BID x 7 days

Other _____

CHLAMYDIA (lab confirmed)

DIAGNOSIS (check one)
○ Asymptomatic ○ Symptomatic, Uncomplicated ○ Pelvic Inflammatory Disease ○ Ophthalmic ○ Other Complications _____

Specimen Date _____

Laboratory _____

SITES (check all sites that tested positive)
☐ Eyes ☐ Pharynx ☐ Urethra ☐ Vagina ☐ Cervix ☐ Urine ☐ Rectum ☐ Other _____

TREATMENT (see CDC guidelines)
Date Prescribed _____
☐ Azithromycin 1g PO
☐ Doxycyline 100 mg PO BID x 7 days
☐ Amoxicillin 500 mg PO TID x 7 days
☐ Levofloxacin 500 mg PO daily x 7 days

Other _____
Date Prescribed _____

SYPHILIS (suspected or probable)

STAGE (check one)
○ Primary (Chancre, etc.) ○ Secondary (Rash, etc.) ○ Early Latent (< 1 year) ○ Unknown Duration or Late ○ Congenital

MANIFESTATIONS (check all that apply)
☐ Neurologic ☐ Otic ☐ Ocular ☐ Other

LAB RESULTS
Specimen Date _____
Nontreponemal (RPR/VDRL) Titer _____
Treponemal _____ Result _____

TREATMENT (see CDC guidelines)
Date(s) Administered _____
Bicillin L - A *(recommended)*
☐ 2.4 MU IM in one dose
☐ 7.2 MU IM total (3 doses of 2.4 MU IM at 7-10 day intervals)

Date Prescribed _____
Doxycycline *(PCN allergy)*
☐ 100 mg BID x 14 days
☐ 100 mg BID x 28 days

Other _____

PARTNER MANAGEMENT

○ In-person evaluation - Number of partners treated following medical evaluation: _____

○ Patient-delivered treatment - Number of partners for whom provider prescribed or provided expedited partner therapy (EPT) medication pack: _____

REPORTING CLINIC INFORMATION

FACILITY NAME	DIAGNOSING CLINICIAN

ADDRESS	CITY	STATE	ZIP

TELEPHONE	DATE	PERSON COMPLETING FORM

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

OFFICE USE ONLY

Entered By _____ Date Entered _____