WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Date:_____/_____/_____

To: Washoe County Health District Sexual Health program
Confidential Fax **(775) 328-3764**

Facility: _____ Phone:_____ Fax:_____

Sender: _____

Re: SEXUALLY TRANSMITTED DISEASES / HIV _____Number of Pages Faxed

**** Fax fully completed form, with client's face sheet, provider notes and lab results * ***
**Additional information may be requested as needed to complete the investigation (per NAC 441A.230). **

CONFIDENTIAL CASE REPORT— SEXUALLY TRANSMITTED DISEASES / HIV

Patient's Last Name:	**First:**	**Initial:**	**DOB:** ____/____/____	**Age:**

Sex:	**Race (Please ✓ one):**	**Ethnicity (✓ one):**	**Address:**		
☐ M ☐ F	☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black ☐ White ☐ Other: _____ ☐ Unknown	☐ Hispanic ☐ Non-Hispanic ☐ Unknown	**City:**	**State:**	**Zip:**
Pregnant: ☐ Yes ☐ No # wks:		**Marital Status:**	**Patient Phone # (home/cell):**		

Medication Allergies:	**Provider's Name:**	**Provider's Phone #:**

Disease: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ HIV
Date of Diagnosis: **(New GC Tx guidance 12/2020)**
Specimen Collection Date: / /

Treatment: ☐ Azithromycin 1g ☐ Ceftriaxone/Rocephin 500 mg IM
☐ L-A Bicillin 2.4 mu IM ☐ Doxy 100 Mg BID x # ____ Days ☐ Other: _____
Tx / Rx Date: _____/_____/_____ Dr.'s office / Prescription

Please complete the following for ALL cases

Sex with: ☐Male ☐ Female ☐ Both
HIV status: ☐Pos ☐ Neg ☐ Unk
Date last tested: _____
If + In Care? **Where?**

Partner info: Name:_____DOB:_____Age:
Tel#:_____Last sex when?_____
☐ Steady ☐ 1x-only ☐ on/off # Partners in last 3 mos?_
☐ Partner F/U: ☐ Hopes ☐ HD ☐ PMD ☐ Other_____☐ Epi-treated?

Please complete the following if reporting Syphilis

Symptoms? ☐ No ☐ Yes-how long? _____
If Yes, ☐ Chancre ☐ Rash ☐ Other_____
Where? ☐ Genital ☐ Oral ☐ Hands ☐ Feet ☐ Body
Neurological Involvement? ☐ No ☐Yes Describe:
Previous Hx of Syphilis? ☐ No ☐ Yes
If Yes, City/State treated_____Year _____
Treated with: ☐ Shots ☐ Pills
Previous Syphilis Test? ☐ No ☐ Yes
If Yes, Date:_____Results: RPR ☐ Negative ☐ Positive
If positive, RPR titer:_____FTA/TPPA: _____

Provider Diagnosis:
☐ Primary Syphilis ☐ Secondary Syphilis
☐ Early Latent ☐ Late Latent
☐ Old previously treated
☐ BFP – (False Positive) *Please include copy of any NR confirmatory tests*

Plan: ☐ Treated on day of visit.
☐ Not treated yet. Appt on: _____
☐ Previously treated. Repeat titer _____
☐ Unable to contact. Reason: _____

Note: To speak with the on-duty Disease Intervention Specialist, contact (775) 328-6161.
For HIV Disease Investigators, contact (775) 328-6142, (775) 328-6147, or (775) 328-6156.

Last date revised: 1/5/2021