Fax Report to the STD Confidential Fax Line: (609) 826-4870

The State of New Jersey Department of Health
Sexually Transmitted Disease Program
STD CASE REPORT FORM
PO Box 363, Trenton NJ 08625-0363 | 609-826-4869

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE (indicate home, work or cell)	SEX AT BIRTH	CURRENT GENDER	IS PATIENT PREGNANT?	ESTIMATED DELIVERY DATE (If pregnant):
	☐Male ☐Female	☐Male ☐Female	☐Yes ☐No ☐Unknown	

ETHNICITY	RACE (Check all that apply)	GENDER OF SEX PARTNER(S)	REASON FOR EXAM (Check one)	DATE OF LAST HIV TEST:
☐Hispanic ☐Non-Hispanic ☐Unknown	☐White ☐Black ☐Asian ☐American Indian/Alaskan Native ☐Native Hawaiian/Other Pacific Islander ☐Other ☐Unknown	☐Male ☐Female ☐Both ☐Unknown	☐Symptomatic ☐Routine exam – no symptoms ☐Exposed to infection	_____ **RESULT:** ☐Pos ☐Neg ☐Unk **IS PATIENT ON PrEP?** ☐Yes ☐No ☐Unknown

DIAGNOSIS – Include lab results when sending case report forms

GONORRHEA

Sites (check all that apply)
☐Cervix ☐Urethra ☐Urine ☐Rectum
☐Pharynx ☐Vagina ☐Other:_____

DATE TREATED:_____(check all that apply)
☐Ceftriaxone 500mg IM ☐Ceftriaxone 1g IM ☐Azithromycin 2g
☐Doxycycline 100mg BIDx7 ☐Gentamicin 240mg IM ☐Cefixime 800mg
☐Other:_____
WAS THE PATIENT GIVEN MEDICATION/PRESCRIPTION FOR THEIR PARTNER(S)? ☐Yes ☐No ☐Unk

CHLAMYDIA

Sites (check all that apply)
☐Cervix ☐Urethra ☐Urine ☐Rectum
☐Pharynx ☐Vagina ☐Other:_____

DATE TREATED:_____(check all that apply)
☐Azithromycin 1g ☐Azithromycin 2g ☐Doxycycline 100mg BIDx7
☐Other:_____
WAS THE PATIENT GIVEN MEDICATION/PRESCRIPTION FOR THEIR PARTNER(S)? ☐Yes ☐No ☐Unk

SYPHILIS

☐Primary (chancre) ☐Secondary (rash, etc.)
☐Early latent (<1 year duration but no symptoms)
☐Late latent (>1 year duration but no symptoms)
☐Unknown duration ☐Congenital
Additional diagnoses (check all that apply):
☐Neuro syphilis ☐Ocular syphilis ☐Otic syphilis

DATE TREATED: _____(check all that apply)
☐Bicillin 2.4mu IMx1 ☐Bicillin 2.4mu IMx3wks ☐Other:_____
DESCRIBE SYMPTOMS:_____
WAS THE PATIENT TESTED FOR SYPHILIS PRIOR TO CURRENT REPORT? ☐Yes ☐No ☐Unk
IF YES, DATE OF LAST RPR:_____ **RESULT**: ☐Pos ☐Neg ☐Unk

OTHER*

☐Chancroid ☐Lymphogranuloma Venereum *Call 609-826-4869 to discuss further

REPORTING CLINIC INFORMATION

PERSON COMPLETING FORM *(first) (last)*	EXAMINING PROVIDER *(first) (last)*	DATE

FACILITY NAME	TELEPHONE *(direct line)*

ADDRESS *(street) (city) (state)*	ZIP CODE

Thank you for reporting a STD. All information will be managed with the strictest confidentiality.