# LOUISIANA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES (STDs)

## PROVIDER INFORMATION

Name of Provider: | Phone: ( ) - | Fax Number: ( ) -

Facility Name: | Email:

Address: | City: | State: | Zip:

Name of Person Reporting: | Position:

## PATIENT INFORMATION

Patient Medical Rec. #: | Insurance: ☐ Private ☐ Medicaid ☐ Unknown ☐ None

First Name: | Middle Initial: | Last Name:

Address: | City: | State: | Zip:

Patient Hm Ph: ( ) - | Patient Wk Ph: ( ) - | Patient Cell Ph: ( ) -

DOB (MM/DD/YYYY): / / | SSN: - - | Emergency Contact:

Sex at Birth: ☐ Male ☐ Female

Gender: ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male

Pregnant: ☐ Yes, Expected Delivery Date: / / ☐ No ☐ Unknown

Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other/Unk

Ethnicity: ☐ Hispanic ☐ Non-Hispanic | Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Gender of Partner(s) **:** ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Unknown

### CHLAMYDIA

☐ Uncomplicated
☐ Ophthalmia neonatorum
☐ Oral / Pharyngeal
☐ Rectal
☐ Pelvic Inflammatory Disease (PID)
☐ Pneumonia
☐ Other (specify): _____

**Date of Specimen Collection:**
_____/_____/_____

**Test(s) Conducted:**
☐ Culture
☐ NAATs
☐ Nucleic Acid Probe
☐ Point of Care Test
☐ Other (specify): _____

**Date Treatment Administered**:
_____/_____/_____

**Date prescription given:**
_____/_____/_____

**Recommended Treatment:**

☐ Azithromycin 1g orally in a single dose
☐ Doxycycline 100 orally twice a day for 7 days
☐ Erythromycin base 500 mg orally 4 times a day for 7days
☐ Amoxicillin 500 mg PO 3 times a day for 7 days **(if pregnant)**
☐ Other (specify): _____

**Name of Testing Laboratory:**

### GONORRHEA

☐ Uncomplicated
☐ Disseminated Gonococcal Infection (DGI)
☐ Ophthalmia neonatorum
☐ Oral / Pharyngeal
☐ Rectal
☐ Resistant Strain
☐ Pelvic Inflammatory Disease (PID)
☐ Other (specify):

**Date of Specimen Collection:**
_____/_____/_____

**Test(s) Conducted**:
☐ Culture
☐ NAATs
☐ Nucleic Acid Probe
☐ Point of Care Test
☐ Other (specify): _____

**Date Treatment Administered:**
_____/_____/_____

**Date prescription given:**
_____/_____/_____

**Recommended Treatment:**

☐ Ceftriaxone 250 mg IM in a single dose **OR**
(if Ceftriaxone is not available)
☐ Cefixime 400 mg orally in a single dose **PLUS**
☐ Azithromycin 1 g orally in a single dose **OR**
☐ Doxycycline 100mg PO twice a day for 7 days

**If allergic to penicillin:**
☐ Gentamicin 240 mg IM in a single dose **OR**
☐ Gemifloxacin 320 mg orally in a single dose **PLUS**
☐ Azithromycin 2 g orally in a single dose
☐ Other (specify): _____

**Name of Testing Laboratory:**

### SYPHILIS

**NOTE: Call to report [(504) 568-7474], then follow-up with form**

☐ Primary (Genital or oral ulcer)
☐ Secondary (Rashes)
☐ Early Latent (<1 year)
☐ Late Latent (>1 year)
☐ Tertiary- Cardiovascular
☐ Tertiary- Neurosyphilis
☐ Congenital
☐ Unknown stage

**Date of Specimen Collection**:
_____/_____/_____

**Test(s) Conducted & Results:**

☐ RPR Titer_____
☐ VDRL Titer _____
☐ MHATP _____
☐ FTA _____
☐ IgG (EIA)_____
☐ TP-PA _____
☐ Other _____

**Recommended Treatment:**

☐ 2.4 million units Benzathine Penicillin G (BIC) IM X 1dose
**Date Administered:** _____/_____/_____

☐ 2.4 million units Benzathine Penicillin G (BIC) IM X 3 doses
**Date 1st Dose Administered:** _____/_____/_____

☐ Doxycycline 100 mg orally twice a day for 14 days
☐ Doxycycline 100 mg orally twice a day for 28 days
☐ Other: _____

**Date prescription given:**_____/_____/_____

**Name of Testing Laboratory:**

### OTHER

☐ Chancroid
☐ Granuloma Inquinale
☐ Herpes Simplex Virus(Neonates only)
☐ Lymphogranuloma Venereum
☐ Other (specify): _____

**Date of Specimen Collection:**
_____/_____/_____

**Test(s) Conducted**:
☐ _____
☐ _____
☐ _____
☐ _____

**Treatment**:
☐ _____
☐ _____

**Date Treatment Administered**:_____/_____/_____

**Date Prescription Given:**_____/_____/_____

**Name of Testing Laboratory**:

For information regarding testing and treating of partners exposed to STD or HIV contact the Regional Operations Manager at (504) 568-7474.

**Mail or FAX form to: Louisiana Office of Public Health STD/HIV Program, PO Box 60630, New Orleans, LA, 70160; (504)568-8384.**
For more information call (504)568-7474. (Form: STD 43 Rev10/2014)

**LOUISIANA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES (STDs)**
**Form: STD 43 Revised October 2014**

**DESCRTIPTION & PURPOSE**
The STD 43 is a single page form to report newly diagnosed, re-infected, and treated STDs with the exception of HIV/AIDS.

Directions for reporting HIV/AIDS cases contact: STD/HIV Program, 1450 Poydras Street Suite 2136, New Orleans, LA 70112, (504)568-7474. For information about HIV/AIDS Surveillance: http://www.hiv.dhh.louisiana.gov.

**INSTRUCTIONS FOR COMPLETING STD 43: CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES**
Use one (1) form per person to report all applicable STDs. P**rint legibly**.

Provider Information: Write the Name, Addresses, Phone number and Name of Person Reporting in the box or place a typed label with the same information over the box. If provider and facility are different, provide information for both. Services provided via the internet **must** list a valid medical provider and facility.

Patient Information: Write the medical record #, Name, Type of Insurance used for visit, Address, Phone numbers, Date of Birth (DOB), Social Security Number (SSN), in the spaces provided. Check the appropriate boxes for Gender, Pregnancy status, marital status, Race, Ethnicity and Gender of Partner(s).

Disease: Check appropriate box (es) in this section depending on the diagnosis. **In addition to completing form, call the STD/HIV Program at (504)568-7474 to report all cases of primary & secondary syphilis.**
For each disease reported complete each box in the appropriate column including:
1. Check the box (es) for the disease(s) being reported
2. Write the date laboratory specimens were collected
3. Write the name of the laboratory where tests were conducted
4. Check the box (es) for type of test(s) conducted that were **positive.** Syphilis test(s) conducted must be reported **with results** to identify new cases:
   - If RPR/VDRL is positive and confirmatory test (e.g., TPPA or IgG-EIA) is negative, report NEGATIVE confirmatory test result also (to validate biological false positives).
   - Enter titer result for the RPR and/or VDRL test (e.g., RPR 1:16, VDRL 1:128).
   - Report non-reactive/negative RPR/VDRL result if confirmatory test is positive (i.e. TPPA or IgG-EIA)

5. Write / check box (es) of medication given; write date treatment was administered or prescription was provided

**Important Note**
Form STD 43 should be mailed to the STD Control Section as soon as the diagnosis is made. The form may be filled before treatment is completed. Patients should not be reported as cases unless the diagnosis is confirmed appropriately. All contacts of STDs should be tested for the disease(s) to which they were exposed. If contacts are treated in the absence of positive laboratory tests, then they are considered epidemiologically treated. Epidemiologic treatment is applicable only to persons exposed to known STD cases. Therefore, the term does not apply to persons who are treated for symptoms only and are not, therefore, definitively diagnosed. Reporting of epidemiologic treatment should be withheld and reported only with positive laboratory tests.

**MAIL or FAX FORM TO:**
LOUISIANA OFFICE OF PUBLIC HEALTH- STD CONTROL PROGRAM
1450 Poydras Street Suite 2136
New Orleans, LA 70112

or

PO BOX 60630
NEW ORLEANS LA 70160

FAX to: (504)568-8384

For questions contact the STD/HIV Program at: 504-568-7474 or visit our web site at: www.std.dhh.louisiana.gov.