

# Louisiana Department of Health Confidential Report of Sexually Transmitted Diseases (STD)

**Mail to:** Louisiana Department of Health-STD/HIV/Hepatitis Program, PO Box 60630, New Orleans, LA 70160 or **FAX to:** (504) 568-8384

|                                                                                                                                                                                                                                             |  |                                                                                                            |                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Date Reported:</b> _____                                                                                                                                                                                                                 |  |                                                                                                            |                                                                                                                                                             |
| <b>Name of Provider:</b> _____                                                                                                                                                                                                              |  | <b>Facility/Clinic Name:</b> _____                                                                         |                                                                                                                                                             |
|                                                                                                                                                                                                                                             |  | <b>Phone #:</b> (    ) (    ) (    )                                                                       |                                                                                                                                                             |
| <b>Facility/Clinic Address:</b> _____                                                                                                                                                                                                       |  | <b>City:</b> _____                                                                                         | <b>State:</b> _____                                                                                                                                         |
|                                                                                                                                                                                                                                             |  | <b>Zip Code:</b> _____                                                                                     |                                                                                                                                                             |
| <b>PATIENT INFORMATION</b>                                                                                                                                                                                                                  |  | <b>Last Name:</b> _____                                                                                    | <b>First Name:</b> _____                                                                                                                                    |
| <b>Medical Rec. No.:</b> _____                                                                                                                                                                                                              |  | <b>MI:</b> _____                                                                                           |                                                                                                                                                             |
| <b>DOB (MM/DD/YYYY):</b> ____/____/____                                                                                                                                                                                                     |  | <b>SSN #:</b> _____                                                                                        | <b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Separated |
| <b>Race:</b> <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown |  |                                                                                                            |                                                                                                                                                             |
| <b>Sex at Birth:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male                                                                                                                                                          |  | <b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino    |                                                                                                                                                             |
| <b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male-to-Female <input type="checkbox"/> Transgender Female-to-Male                                                        |  | <b>Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                                                                                                             |
|                                                                                                                                                                                                                                             |  | <b>Expected Delivery Date:</b> ____/____/____                                                              |                                                                                                                                                             |
| <b>Address:</b> _____                                                                                                                                                                                                                       |  | <b>City:</b> _____                                                                                         | <b>State:</b> _____                                                                                                                                         |
|                                                                                                                                                                                                                                             |  | <b>Zip Code:</b> _____                                                                                     |                                                                                                                                                             |
| <b>Cell Phone:</b> (    ) (    ) - (    ) (    ) (    )                                                                                                                                                                                     |  | <b>Alt. Phone:</b> (    ) (    ) (    ) - (    ) (    ) (    )                                             | <b>Pt. Email:</b> _____                                                                                                                                     |
| <b>Gender of Sex Partner(s):</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male-to-Female <input type="checkbox"/> Transgender Female-to-Male <input type="checkbox"/> Unknown     |  |                                                                                                            |                                                                                                                                                             |

| <b>LABORATORY NAME:</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CHLAMYDIA</b>        | <b>Date of Specimen Collection:</b><br>____/____/____<br><br><input type="checkbox"/> Urogenital (Urine, cervical, etc.)<br><input type="checkbox"/> Oral/ Pharyngeal<br><input type="checkbox"/> Rectal<br><input type="checkbox"/> Ophthalmia neonatorum<br><input type="checkbox"/> Proctitis<br><input type="checkbox"/> Pelvic Inflammatory Disease (PID)<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Lymphogranuloma Venereum (LGV)<br><input type="checkbox"/> Other (specify): _____                                                                                     | <b>Test Type:</b><br><input type="checkbox"/> Culture<br><input type="checkbox"/> NAAT<br><input type="checkbox"/> Nucleic Acid Probe<br><input type="checkbox"/> Point of Care Test<br><input type="checkbox"/> Other (specify): _____                                                                                                                                                    | <b>Date Treatment Administered or Prescription Given:</b><br>____/____/____<br><br><input type="checkbox"/> Doxycycline 100mg orally 2 times/day for 7 days<br><br><b>Alternative Treatment:</b><br><input type="checkbox"/> Azithromycin 1 gm orally in a single dose<br><b>OR</b><br><input type="checkbox"/> Levofloxacin 500 mg orally once daily for 7 days.<br><b>During pregnancy</b><br><input type="checkbox"/> Azithromycin 1 g orally in a single dose.<br><br><b>Alternative:</b><br><input type="checkbox"/> Amoxicillin 500 mg orally 3 times/day for 7 days.<br><input type="checkbox"/> Other (specify): _____ |
| <b>GONORRHEA</b>        | <b>Date of Specimen Collection:</b><br>____/____/____<br><br><input type="checkbox"/> Urogenital (Urine, cervical, etc.)<br><input type="checkbox"/> Oral/Pharyngeal<br><input type="checkbox"/> Rectal<br><input type="checkbox"/> Disseminated Gonococcal Infection (DGI)<br><input type="checkbox"/> Ophthalmia neonatorum<br><input type="checkbox"/> Resistant Strain<br><input type="checkbox"/> Proctitis<br><input type="checkbox"/> Pelvic Inflammatory Disease (PID)<br><input type="checkbox"/> Other (specify): _____                                                                      | <b>Test Type:</b><br><input type="checkbox"/> Culture<br><input type="checkbox"/> NAAT<br><input type="checkbox"/> Nucleic Acid Probe<br><input type="checkbox"/> Point of Care Test<br><input type="checkbox"/> Other (specify): _____                                                                                                                                                    | <b>Date Treatment Administered or Prescription Given:</b><br>____/____/____<br><br><input type="checkbox"/> Ceftriaxone 500mg IM single dose for persons weighing <150 kg (300 lb).<br><input type="checkbox"/> Persons weighing ≥150 kg (300 lb), 1 g of IM ceftriaxone.<br><br><b>Alternative Treatment if above Rx is not available:</b><br><input type="checkbox"/> Gentamicin 240mg IM in a single dose <b>PLUS</b> Azithromycin 2g orally in a single dose <b>OR</b><br><input type="checkbox"/> Cefixime 800 mg orally in a single dose.<br><input type="checkbox"/> Other (specify): _____                             |
| <b>SYPHILIS</b>         | <b>Date of Specimen Collection:</b><br>____/____/____<br><br><input type="checkbox"/> Primary (Genital or oral ulcer)<br><input type="checkbox"/> Secondary (Rashes/condyloma lata)<br><input type="checkbox"/> Early non-primary non-secondary<br><input type="checkbox"/> Unknown duration or Late syphilis<br><input type="checkbox"/> Tertiary - Cardiovascular<br><input type="checkbox"/> Tertiary - Neurosyphilis<br><input type="checkbox"/> Ocular syphilis<br><input type="checkbox"/> Orosyphilis<br><input type="checkbox"/> Congenital<br><input type="checkbox"/> Other (specify): _____ | <b>Test(s) Conducted &amp; Results:</b><br><input type="checkbox"/> RPR Titer _____<br><input type="checkbox"/> VDRL Titer _____<br><input type="checkbox"/> MHA-TP _____<br><input type="checkbox"/> FTA _____<br><input type="checkbox"/> IgG (EIA) _____<br><input type="checkbox"/> TP-PA _____<br><input type="checkbox"/> Point of Care Test<br><input type="checkbox"/> Other _____ | <b>Date Treatment Administered:</b> ____/____/____<br><input type="checkbox"/> 2.4 million units Benzathine Penicillin G (BIC) IM X 1 dose.<br><br><b>Date 1<sup>st</sup> Dose Administered:</b> ____/____/____<br><input type="checkbox"/> 2.4 million units Benzathine Penicillin G (BIC) IM X 3 doses.<br><br><b>Alternate Treatment:</b><br><input type="checkbox"/> Doxycycline 100 mg orally twice a day for 14 days<br><input type="checkbox"/> Doxycycline 100 mg orally twice a day for 28 days<br><input type="checkbox"/> Other (specify): _____                                                                    |
| <b>OTHER</b>            | <b>Date of Specimen Collection:</b><br>____/____/____<br><input type="checkbox"/> Herpes Simplex Virus (Neonates)<br><input type="checkbox"/> Other (specify): _____                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Test(s) Conducted &amp; Results:</b><br><input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____                                                                                                                                                                                                                                              | <b>Treatment:</b><br><input type="checkbox"/> _____<br><input type="checkbox"/> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

# LOUISIANA DEPARTMENT OF HEALTH CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED INFECTIONS (STD)

## **DESCRIPTION & 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:** Submit the appropriate HIV Reporting form to the STD/HIV/Hepatitis Program, 1450 Poydras Street Suite 2136, New Orleans, LA 70112 or call (504) 568-7474. For additional information about HIV Surveillance, go to: <http://www.LAHHUB.org>

## **INSTRUCTIONS FOR COMPLETING the STD 43:**

Use one (1) form per person to report all applicable STDs. *PLEASE Print legibly.*

**Provider Information:** Write the Date the Report will be submitted, Provider Name Reporting, Provider Address, and Phone number in the boxes or place designated or 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 name.

**Patient Information:** Write the medical record #, Last Name/First Name/Middle Initial, Date of Birth (DOB), Social Security Number (SSN), in the spaces provided. Check the appropriate box (es) for Marital status, Race, Sex at Birth, Gender, Ethnicity, Pregnancy status, Address, City/State/Zip Code, Phone number(s) and Email. Also check the appropriate box for Gender of Sex Partner(s).

**Laboratory:** Write the Name of the laboratory where the tests were conducted.

**Disease:** Check appropriate box (es) in this section depending on the diagnosis. In addition to completing the form, call the STD/HIV/Hepatitis Program at (504)568-7474 to report all cases of infectious syphilis such as primary & secondary syphilis, per the states reporting requirements.

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. 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, include titers:
  - 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, IgG-EIA, FTA, etc.)
4. Write / check box (es) of medication given; write date treatment was administered and prescription was provided

## **Important Note:**

Form STD 43 should be mailed to the STD/HIV/Hepatitis Program 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 by appropriate positive tests. 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 or in priority cases investigated by the Louisiana Department of Health-Office of Public Health STD/HIV/Hepatitis Disease Intervention Specialist(DIS).

## **MAIL or FAX FORM**

### **Mail to:**

LOUISIANA DEPARTMENT OF HEALTH- STD/HIV/Hepatitis Program  
1450 Poydras Street Suite 2136 Or  
New Orleans, LA 70112

PO BOX 60630  
NEW ORLEANS LA 70160

**FAX to:** (504)568-8384

For questions contact the STD/HIV/Hepatitis Program at: 504-568-7474 or visit our web site at: <http://www.LAHHUB.org>.  
Thank you for reporting and supporting the control and prevention efforts of Sexually Transmitted Infections and Disease in Louisiana.