



FLORIDA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES

<http://seminolecohealth.com>

STD Surveillance

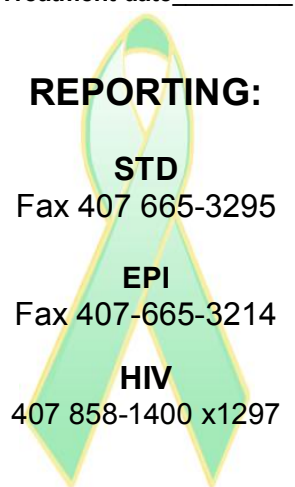
Attn: Betty Chillon
407 665-3285 or 407 665-3286
Fax: 407 665-3295

400 W Airport Blvd
Sanford, FL 32773

Patient Name:
DOB:
SS#:
Address:

Phone:
Race: White__ Black__ Other__ AM Indian/Alaskan__
Asian/Pacific Islander__ Hispanic__ Non-Hispanic__

Female _____ Male _____
Not Pregnant _____ Pregnant _____
Pregnancy due date _____

CHLAMYDIA	GONORRHEA	SYPHILIS	OTHER
<input type="checkbox"/> Ophthalmia <input type="checkbox"/> Oral/Pharyngeal <input type="checkbox"/> Pelvic Inflammatory Disease (PID) <input type="checkbox"/> Pneumonia <input type="checkbox"/> Uncomplicated <div style="border: 1px solid black; padding: 5px; text-align: center; color: red;"> VISIT OUR WEBSITE FOR AN ELECTRONIC COPY OF OUR REPORTING FORM </div>	<input type="checkbox"/> Disseminated Gonococcal <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Oral/Pharyngeal <input type="checkbox"/> Other resistant strain <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Penicillinase-Producing Neisseria Gonorrhoea (PPNG) <input type="checkbox"/> Rectal <input type="checkbox"/> Uncomplicated	___ RPR 1: _____ Types of Confirmatory test <input type="checkbox"/> TP-PA positive <input type="checkbox"/> FTA positive <input type="checkbox"/> IgG positive <input type="checkbox"/> Other _____ Diagnosis <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Early Latent (< 1 yr) <input type="checkbox"/> Late Latent <input type="checkbox"/> Tertiary - Cardio <input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Congenital	<input type="checkbox"/> Chancroid <input type="checkbox"/> Granuloma Inguinal <input type="checkbox"/> Herpes Simplex Only report through age 11 <input type="checkbox"/> Human Papillomavirus Only report through age 11 <input type="checkbox"/> Lymphogranuloma <input type="checkbox"/> Venereum <input type="checkbox"/> Other (specify) _____
Result Date	Result Date	Result Date	Result Date
Collection date	Collection date	Collection date	Collection date
Reporting laboratory	Reporting laboratory	Reporting laboratory	Reporting laboratory
Treatment date _____ <input type="checkbox"/> Azithromycin 1 gm <input type="checkbox"/> Doxycycline 100 mg BID x 7 Days <input type="checkbox"/> Other _____ IF PREGNANT <input type="checkbox"/> Azithromycin 1 gm <input type="checkbox"/> Erythromycin 500 QID x 7 Days <input type="checkbox"/> Amoxicillin 500 TID x 7 Days <input type="checkbox"/> Was sex partner treated? If no, was sex partner referred to Health Department? _____	Treatment date _____ <input type="checkbox"/> Cefixime 400 mg <input type="checkbox"/> Ceftriaxone 125 mg <input type="checkbox"/> Ceftriaxone 250 mg <input type="checkbox"/> Azithromycin 2 gm <input type="checkbox"/> Cefuroxime 1 gm <input type="checkbox"/> Vantin 400 mg <input type="checkbox"/> Other _____ IF PREGNANT <input type="checkbox"/> Cefixime 400 mg <input type="checkbox"/> Ceftriaxone 125 <input type="checkbox"/> Ceftriaxone 250 <input type="checkbox"/> Azithromycin 2 gm <input type="checkbox"/> Was sex partner treated? If no, was sex partner referred to Health Department? _____	Treatment dates: 2.4 BIC #1 _____ 2.4 BIC #2 _____ 2.4 BIC #3 _____ <input type="checkbox"/> Doxycycline 100 BID x 14 days Date _____ <input type="checkbox"/> Tetracycline 100 QID x 14 days Date _____ <input type="checkbox"/> Other _____ IF PREGNANT <input type="checkbox"/> Was sex partner treated? If no, was sex partner referred to Health Department? _____	Treatment date _____ <div style="text-align: center;">  </div>

PROVIDER INFORMATION

Practice Name _____

Area code & phone

Address _____

() _____