

# SEXUALLY TRANSMITTED INFECTIONS LABORATORY AND MORBIDITY CASE REPORT

Additional information for completing the form is on page 2

## A. PATIENT Demographic Information

Last Name		First Name		Middle Initial
Date of Birth (MM/DD/CCYY)	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Transgender: <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male <input type="checkbox"/> Gender Non-specific	Pregnancy Status Pregnant: <input type="checkbox"/> Yes: Number of weeks: <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Patient's Street Address (Enter patient's street address only)			Apartment Number	Phone Number
City		State	Zip Code	County of Residence
Race <input type="checkbox"/> African American <input type="checkbox"/> Alaskan/Native American <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Races		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Gender of Sex Partners <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender: <input type="checkbox"/> MtF <input type="checkbox"/> FtM <input type="checkbox"/> G N-S

## B. DISEASE CLASSIFICATION RELATED TO DIAGNOSIS

Date of Onset Symptoms (MM/DD/CCYY):	Describe Any Symptoms:
<input type="checkbox"/> <b>Syphilis (S)</b> <input type="checkbox"/> Primary (Chancre present) <input type="checkbox"/> Secondary (Body rash, palmer and/or plantar) <input type="checkbox"/> Early Non-Primary/Non-Secondary (No symptoms less than 1 year) <input type="checkbox"/> Late, Unknown Duration Syphilis <input type="checkbox"/> Adverse Outcome: <input type="checkbox"/> Neurologic <input type="checkbox"/> Ocular <input type="checkbox"/> Otic <input type="checkbox"/> Late Clinical Manifestations	
<input type="checkbox"/> <b>Chlamydia (CT) and/or Gonorrhea (GC)</b> <input type="checkbox"/> Uncomplicated Urogenital (Urethritis, cervicitis) <input type="checkbox"/> Salpingitis — CT/GC Pelvic Inflammatory Disease (PID) <input type="checkbox"/> Ophthalmia/Conjunctivitis <input type="checkbox"/> Disseminated Gonococcal Infection, see <a href="#">F-02962</a> <input type="checkbox"/> Antibiotic Susceptibility Test (AST): <input type="checkbox"/> Antibiotic-Resistant Gonorrhea (ARGC) <input type="checkbox"/> Suspect Treatment Failure (GC)	
<input type="checkbox"/> <b>Chancroid</b> <input type="checkbox"/> <b>Non-CT/GC PID</b>	

## C. LABORATORY TEST(S) RELATED TO CURRENT DIAGNOSIS

Test Type (Use one line per test)	Specimen Source: (Cervix, vaginal, urethra, blood, urine, throat, rectum, etc.)	Test Result(s): Row 4 for Gonorrhea AST	
1		<input type="checkbox"/> Pos <input type="checkbox"/> Neg Titer 1:	
2		<input type="checkbox"/> Pos <input type="checkbox"/> Neg Titer 1:	
3		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
4	<input type="checkbox"/> <b>AST</b> <input type="checkbox"/> <b>Ceftriaxone (MIC &gt; 0.125 µg/ml)</b> or <input type="checkbox"/> <b>Cefixime (MIC ≥ 0.25 µg/ml)</b>	<input type="checkbox"/> Culture <input type="checkbox"/> NAAT AST MIC: AST MIC:	
Date Specimen Collected (MM/DD/CCYY):		Date Specimen Analyzed (MM/DD/CCYY):	
Name of Attending Physician or Provider Ordering Test:		Name of Laboratory Performing Test(s):	
Patient Treated <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) of Treatment (MM/DD/CCYY) 1st: 2nd: 3rd:	HIV Status <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Date Reported to LTHD (MM/DD/CCYY)

## D. TREATMENT (RX) INFORMATION

<input type="checkbox"/> Benzathine penicillin G 2.4 m.u. IM x 1 (S) <input type="checkbox"/> Benzathine penicillin G 2.4 m.u. IM x 3 (S) <input type="checkbox"/> Doxycycline 100mg PO BID for 7d (CT) <input type="checkbox"/> Doxycycline 100mg PO BID for 14d (S, Alt) <input type="checkbox"/> Doxycycline 100mg PO BID for 28d (S, Alt)  (Alt) Alternative Therapy	<input type="checkbox"/> Azithromycin 1g PO x 1 (CT, Alt) <input type="checkbox"/> Ceftriaxone 500mg IM (for patients under 300 lbs.) (GC) <input type="checkbox"/> Ceftriaxone 1,000mg IM (for patients 300 lbs. or over) (GC) <input type="checkbox"/> Cefixime 800mg (GC, Alt) <input type="checkbox"/> Gentamicin 240mg and 2g Azithromycin (GC, Alt) <input type="checkbox"/> Other, list:	<b>Expedited Partner Therapy (EPT)</b> EPT provided for partner(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No  Doxycycline 100mg PO BID for 7d (CT) Azithromycin 1g PO x 1 (CT) Cefixime 800mg PO (GC) Other:
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## E. REPORTING SOURCE (Required)

Name of Person Reporting	Phone Number	Local and Tribal Health Department (LTHD)
Agency Reporting	Phone Number	
Street Address		Date Received by LTHD (MM/DD/CCYY)
City, State, and Zip Code		
Comments (Including additional treatment dates):		

**Information for Completing  
Sexually Transmitted Infections (STI) Laboratory and Morbidity Case Report**

Information reported on this form is authorized by Wis. Stat. § 252.11. All information contained in this report is confidential except as may be needed for the purpose of investigation, control, and prevention of communicable diseases (infections).

### General Instructions

This STI case report form is to be used by laboratories, physicians, hospitals, STI clinics, local and tribal health departments (LTHDs), or other agencies within the state of Wisconsin to report suspected or confirmed sexually transmitted infections.

**As specified in rules (Wis. Stat. § 252.11) promulgated by the Wisconsin Department of Health Services (DHS), ALL information (laboratory and morbidity) is to be reported to the LTHD/health officer in the county the patient resides within 72 hours.**

LTHDs must report to the DHS at least weekly.

### Reportable Sexually Transmitted Infections

Chancroid	Sexually Transmitted Pelvic Inflammatory Disease (PID)
Chlamydia (CT)	Syphilis (All stages)
Gonorrhea (GC)	

### Specific Instructions

**SECTION A — Patient Demographic Information: Complete ALL information. This section is for the patient's information ONLY.**

For date of birth use the following format MM/DD/CCYY. According to Wis. Stat. § 252.11, the patient's complete mailing information, street address, city, county, state, zip code, and their phone number are mandatory. The gender, race, ethnicity, pregnancy status, number of weeks pregnant of the patient, and gender of the sex partners of the patient should be noted on the form.

**SECTION B — Infection Classification Related to Diagnosis:** Check box for each infection suspected or confirmed. See the Center for Disease Control (CDC) Sexually Transmitted Infection Treatment Guidelines <https://www.cdc.gov/std/treatment-guidelines/default.htm> for proper treatment dosage and administration and additional case classification information. To report infections, choose syphilis, chlamydia (CT), gonorrhea (GC), chancroid, or Non-CT/GC PID, and then check the box of the infection and the subtype or complication as applicable. For disseminated gonococcal infections (DGI) please use the <https://www.dhs.wisconsin.gov/forms/f02962.pdf>. Disseminated Gonococcal Infection (DGI) Provider Worksheet and submit it with this form.

**SECTION C — Laboratory Test(s) Related to Diagnosis: Use a single line to report information on each test.** If reporting more than four positive tests on the same individual, use an additional form and attach it to the original form.

- **Test Type(s):** Indicate the type of test used to confirm the diagnosis. Examples: VDRL, FTA-ABS, GC or CT NAAT; GC culture
- **Specimen Source:** Indicate anatomical specimen collection site. Examples: urine, cervix, vaginal, urethra, rectum, pharyngeal, etc.
- **Test Results:** Antibiotic Susceptibility Testing (AST MIC) levels testing is specific for gonorrhea antibiotic susceptibility testing. For more information on AST testing please contact the State of Wisconsin STI Unit at 608-266-7365.
- **Name of attending physician or provider ordering test, and name of laboratory providing testing:** Provide the name of the treating and/or attending physician, and the name of the laboratory performing the tests.

**SECTION D — Treatment (Rx) Information:** Check all Rx related to this case report. If reporting other Rx, follow Rx format used on this form. Include the name of the drug (for example doxycycline, ceftriaxone, etc.), how it is administered (PO, IM), frequency (QD, BID, TID), dosage (100mg, 2.4 m.u. etc.) provided. Expedited Partner Therapy (EPT) allows medical providers to prescribe, dispense, or furnish medication to sex partners of patients diagnosed with trichomoniasis, gonorrhea, or *Chlamydia trachomatis* infection without a medical evaluation of the sex partner. Be sure to list number of medication packs, or prescriptions provided to the original patient for their sex partners. EPT should be used to supplement not supplant current STI control efforts described in Wis. Stat. § 252.11. More information is available on the DHS webpage <https://www.dhs.wisconsin.gov/std/health-pros.htm>.

**For more information, see the CDC Sexually Transmitted Infections Treatment Guidelines webpage:** <https://www.cdc.gov/std/treatment-guidelines/default.htm>.

**SECTION E — Reporting Source:** Indicate the name, title, phone number, and mailing address for the individual completing this report. Program staff may contact the individual completing the form, or the attending physician for questions regarding the case report.

**Report Submission Instructions:** Medical Providers can mail or fax a completed hard-copy form **within 72 hours** to the LTHD in the county the patient resides. LTHD addresses are available at <https://www.dhs.wisconsin.gov/lh-depts/counties.htm>. Submit electronic reports via Wisconsin Electronic Disease Surveillance System (WEDSS) Web Report, or directly into WEDSS. LTHDs should enter information into WEDSS. Call the State of Wisconsin STI Unit at 608-266-7365 with questions.

**NOTE:** Sex partner referral/interview: Use the WEDSS STI electronic forms/tabs or hardcopy Field Record form (73.2936S), which is electronic in WEDSS - to document information on sex partners, suspects, and associates. When a named sex partner, suspect, or associate resides outside of the initiating agency's jurisdiction (disposition K), a Field Record should be completed, and routed to the appropriate LTHD for epidemiologic follow-up, or to the Division of Public Health, if the patient's address is from outside the state of Wisconsin.