FLORIDA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASE

PLEASE ENCLOSE RELEVANT LABS

To report STDs, contact Orange County Health Department STD Surveillance:

Phone: (407) 858-1445

Fax: (407) 845-6134

PROVIDER INFORMATION

____
Physician/Provider Name

____
Person Reporting (Print name)

____
Address

(__________)______________________
Telephone

____
City

________ **State** ________ **Zip Code** ________ **County**

PATIENT INFORMATION

Name: ______________________________

DOB: ________________ **Gender:** ☐ Male ☐ Female

Address: ______________________________

Phone:(__________)________________

City: ____________________

State: ____________________ **Zip Code:** __________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

****Pregnancy status**:** ☐ **Not Pregnant** ☐ **Pregnant**
IMPORTANT please complete

Last menstrual period: ______________________________

Expected delivery date:______________________________

Most recent HIV Test date: ______________________

Delivery location: ______________________________

Emergency Contact: ______________________________

Emergency Contact Phone: ______________________

Chlamydia		Gonorrhea		Syphilis
☐ Chlamydia positive Treatment date: ________________		☐ Gonorrhea positive Treatment date: ________________		☐ Syphilis positive
___Uncomplicated ___Ophthalmia ___Oral	___Pelvic inflammatory disease __Rectal	___Uncomplicated ___Disseminated Gonococcal ___Ophthalmia	___Oral/Pharyngeal ___Rectal	Related symptoms: ____________________ ______________________________ Symptom start date: ________________
CT Treatment information ___Azithromycin 1 gm** ___Doxycycline 100 mg BID x 7 Days** ___Levofloxacin 500 mg x 7 Days ___Ofloxacin 300 mg BID x 7 Days ___Amoxicillin 500 mg TID x 7 Days ___Erythromycin base 500 QID x 7 Days **IF PREGNANT** ___Azithromycin 1 gm** ___Erythromycin base 500 QID x 7 Days ___Amoxicillin 500 TID x 7 Days **** CDC Recommended Regimen** **NOTE: Any treatment used other than recommended treatment will need a Test of Cure 3 weeks after completion of therapy.** **Test of Cure less than 3 weeks after completion of therapy could yield false positive result**		**GC Treatment information** **Uncomplicated gonococcal infections of the cervix, urethra, rectum, pharynx, and pregnant patients:** ___ Ceftriaxone 500 mg** **ONLY IF** The patient has severe cephalosporin allergy: ___ Azithromycin 2 gm in a single oral dose AND Test of care in 1 week ___ Other (Please Specify) **** CDC Recommended Regimen:** https://www.cdc.gov/std/treatment-guidelines/default.htm		**Confirmatory test type** ___FTA-ABS ___TP-AB ___IgG-EIA ___TP-PA ___Not ordered **Current titer** 1: __________ ____No titer done **Treatment dates:** 2.4 BIC #1____________ 2.4 BIC #2____________ 2.4 BIC #3____________ OR ___ Doxycycline 100 BID x 14 days **Date** __________ ___ Doxycycline 100 BID x 28 days **Date** __________ **Previous history of syphilis infection?** **YES / NO** **Previous titer (if known):** 1: __________ **Date of last negative RPR:** ______________

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Please visit our website for an electronic copy of our reporting form