



# Communicable Disease Confidential Sexually Transmitted Infection Reporting Form

**Reportable Tests:**

1. **Syphilis:** All reactive, weakly reactive, and borderline serologic and spinal fluid tests. All darkfield examinations finding organisms resembling treponema pallidum.
2. **Gonorrhea:** All gram stain smears and cultures finding gram negative intracellular diplococi resembling neisseria gonorrhoeae.
3. **Other:** All positive test findings for the presence of neisseria gonorrhoeae and chlamydia trachomatis.

**Note:** The health department will routinely follow up on syphilis, gonorrhea and HIV. Chlamydia follow-up with the patient will only be done when requested by the healthcare provider.

<b>P A T I E N T</b>	LAST NAME		FIRST NAME		INITIAL	
	ADDRESS (Street & Number or P.O. Box)			CITY/TOWN	STATE	ZIP CODE
	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F		RACE W B A PI AI AN O U	ETHNICITY H NH	PHONE NUMBER
	Race group: W-White B-Black A-Asian PI-Pacific Islander AI-American Indian AN-Alaskan Native H-Hispanic NH-Non Hispanic O-Other U-Unknown					
	SPECIMEN SUBMITTED BY (Name of Physician or Institution)				DATE SPECIMEN TAKEN	
	ADDRESS					
	Site Specimen taken					
NAME OF LABORATORY PROCESSING SPECIMEN						
ADDRESS						
LABORATORY FINDINGS (Specify Test Performed and Results)				MICHIGAN DEPARTMENT OF COMMUNITY HEALTH RULE 325.173, IN CONJUNCTION WITH RULE 325.172, STATES "A CLINICAL LABORATORY SHALL REPORT LABORATORY EVIDENCE OF ANY INFECTIONS SPECIFIED WITH 3 DAYS OF DISCOVERY., TO THE APPROPRIATE LOCAL HEALTH DEPARTMENT." IN ADDITION, "A PYSICIAN SHALL REPORT EACH CASE OF A SERIOUS COMMUNICABLE DISEASE SPECIFIED, EXCEPT FOR HUMAN IMMUNODEFICIENCY VIRUS INFECTION, TO THE APPROPRIATE LOCAL HEALTH DEPARTMENT." "A REPORT SHALL BE TRANSMITTED IN A MANNER PRESCRIBED OR APPROVED BY THE APPROPRIATE LOCAL HEALTH DEPARTMENT."		
EXAMINER	DATE LABORATORY FINDINGS REPORTED					

### DIAGNOSIS AND TREATMENT INFORMATION

<p style="text-align: center;"><b>SYPHILIS (SPECIFY STAGE)</b></p> <input type="checkbox"/> 710 PRIMARY (CHANCRE PRESENT) <input type="checkbox"/> 720 SECONDARY (RASH/OTHER SYMPTOMS PRESENT) <input type="checkbox"/> 730 EARLY LATENT (UNDER 1 YEAR DURATION) <input type="checkbox"/> 740 LATENT SYPHILIS (DURATION UNKNOWN) <input type="checkbox"/> 745 LATE LATENT SYPHILIS (OVER 1 YEAR DURATION) <input type="checkbox"/> 750 LATE SYPHILIS (WITH MANIFESTATIONS) <input type="checkbox"/> 760 NEUROSYPHILIS <input type="checkbox"/> 790 CONGENITAL <input type="checkbox"/> NOT INFECTED (BIOLOGIC FALSE POSITIVE)	<p style="text-align: center;"><b>GONORRHEA (SPECIFY TYPE)</b></p> <input type="checkbox"/> 300 UNCOMPLICATED <input type="checkbox"/> 350 RESISTANT <input type="checkbox"/> 490 PELVIC INFLAMMATORY DISEASE <input type="checkbox"/> 380 DISSEMINATED <input type="checkbox"/> 390 OPHTHALMIA/CONJUNCTIVITIS	<p style="text-align: center;"><b>CHLAMYDIA (SPECIFY TYPE)</b></p> <input type="checkbox"/> 200 UNCOMPLICATED <input type="checkbox"/> 490 PELVIC INFLAMMATORY DISEASE <input type="checkbox"/> 280 DISSEMINATED (REITER'S SYNDROME) <input type="checkbox"/> 290 OPHTHALMIA/CONJUNCTIVITIS
<p><b>OTHER VENEREAL DISEASES (SPECIFY)</b></p> <input type="checkbox"/> 100 CHANCROID <input type="checkbox"/> 500 GRANULOMA INGUINALE <input type="checkbox"/> 600 LYMPHOGRANULOMA VENERUM		
HAS PATIENT BEEN TREATED FOR <b>THIS</b> INFECTION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		IF YES, DATE OF TREATMENT: (mm/dd/yyyy)
<p><b>SPECIFY DRUG/DOSAGE:</b></p> <input type="checkbox"/> 1 G AZITHROMYCIN <input type="checkbox"/> 100 mg DOXYCYCLINE 2x/day for 7 days <input type="checkbox"/> 500 mg ERYTHROMYCIN 4x/day for 7 days <input type="checkbox"/> 800 mg ERYTHROMYCIN 4x/day for 7 days <input type="checkbox"/> 500 mg LEVOFLOXACIN for 7 days <input type="checkbox"/> OTHER (Specify): _____ <input type="checkbox"/> UNKNOWN		
WAS THE PATIENT HAVING SYMPTOMS? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THE PATIENT PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
TREATED BY (Physician)	ADDRESS	DATE REPORTED

**Send reports to: Secured fax line (231) 547-6238, or call 1-800-432-4121 or (231) 547-0295.**

**If you have any questions, please call:**  
**Antrim County** Rhonda Decker 231-533-1005  
**Charlevoix County** Lindsay Beauvais 231-547-7622  
**Emmet County** Katelyn Nellis 231-347-4102  
**Otsego County** Jessica Maczik 989-732-6877