PLEASE ENCLOSE LAB

FLORIDA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES

TO REPORT HIV/AIDS
Contact: Pat Leach
PHONE: 772-462-3875 or
FAX: 772-462-3809
TO REPORT STDs
Contact: Anthony Sanchez, DIS
PHONE: (772) 794-7471 or (772) 794-7475
FAX: (772) 794-7482

PROVIDER INFORMATION

DATE REPORTED_____

Physician/Provider Name _____

Person Reporting (Print Name) _____

Address _____

Telephone (_____) _____

City _____ **State** _____ **Zip code** _____ **County** _____

PATIENT INFORMATION

Medical Record #:_____

Name:_____ DOB:_____ Gender: Male ☐ Female ☐

SSN:_____ Marital Status: _____

Address:_____ City:_____ State:_____ Zip code:_____

Phone:_____ Cell Phone:_____

Race: White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Pacific Islander Ethnicity: ☐ Hispanic Non-Hispanic ☐

If female, pregnancy status: ☐ Not Pregnant ☐ Pregnant LMP_____ EDD_____ Weeks_____

Most Recent HIV Test Date:_____ Location:_____

Emergency Contact:_____ Phone:_____

Spouse/Partner Name:_____ Age/DOB:_____

Address:_____ City:_____ State:_____ Zip code:_____

Phone:_____ Cell Phone:_____

CHLAMYDIA

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Treatment:

☐ Doxycycline 100mg orally 2x a day for 7 Days

Date of Treatment_____

If patient is allergic to Doxycycline:

☐ ***Azithromycin 1gm orally Single Dose***

OR

☐ ***Levofloxacin 500mg orally 1x a day for 7 days***

Pregnancy

☐ Azithromycin 1gm orally Single Dose

GONORRHEA

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Treatment:

☐ Ceftriaxone 500mg IM x 1 dose

☐ **If ≥150kg:** Ceftriaxone 1gm IM x 1 dose

Date of Treatment_____

If patient is allergic to Ceftriaxone:

☐ ***Gentamicin 240mg IM single dose***

PLUS

Azithromycin 2gm orally Single Dose

SYPHILIS

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Treatment and Date (M/D/Y):

☐ 2.4mu Bicillin L-A (____/____/____)

☐ 2.4mu Bicillin L-A (____/____/____)

☐ 2.4mu Bicillin L-A (____/____/____)

Date of Treatment _____

☐ ***If patient is allergic to PCN and not pregnant: Doxycycline 100mg orally 2x a day for 14 Days for primary or secondary syphilis***

Was partner treated? YES ☐ NO ☐ Name of Partner:_____

Treatment:_____ Date of Treatment:_____

☐ **CLIENT CONTACTED** ☐ **UNABLE TO CONTACT CLIENT**

Comments:_____

TO REPORT A SEXUALLY TRANSMITTED DISEASE PHONE OR FAX:
EPIDEMIOLOGY DEPARTMENT, FLORIDA DEPARTMENT OF HEALTH IN INDIAN RIVER COUNTY
1900 27TH STREET, VERO BEACH, FLORIDA 32960
PHONE: (772) 794-7471 CONFIDENTIAL FAX: (772) 794-7482