STD PROGRAM Florida HEALTH Palm Beach County

# FLORIDA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES [Gonorrhea, Chlamydia & Syphilis Infections]

***PLEASE ENCLOSE LABS***

FAX STD REPORT AND LABS TO:

**eFax: 561-840-0148**

*Contact numbers:*

☎ 561-803-7316
☎ 561-803-7326

***DOH will call if additional information is needed.***

## PROVIDER INFORMATION

**Physician / Provider Name**

**Address**

**City**

**DATE REPORTED:**

**Person Reporting (Print Name)**

**Telephone**

**State** **Zip-code** **County**

## PATIENT INFORMATION

* Required fields

***Name:** ***DOB:**

***Address:** **City:** **State:** **Zip code:**

***Phone:** **Emergency Contact:**

***Birth Sex:** ☐ Male ☐ Female

***Gender:** ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M

***Race:** White☐ Black/African American☐ Asian ☐ American Indian☐ Pacific Islander☐ Other ☐

***Ethnicity:** Hispanic☐ Non-Hispanic☐

***Pregnancy status:** Not pregnant☐ Pregnant☐

***Signs & Symptoms:***

☐ Dysuria ☐ Discharge ☐ Itching ☐ Odor ☐ Pain
☐ Genital/Anal lesion ☐ Skin lesion ☐ Rash ☐ Other

_____
*Description & duration*

***If pregnant, please complete:***

| LMP: | EDD: | Weeks: |
|---|---|---|

**HIV test ordered?** YES☐ NO☐ Date: _____

**Negative HIV test?** YES☐ NO☐ Date: _____

**Syphilis test ordered?** YES☐ NO☐ Date: _____

**Negative Syphilis test?** YES☐ NO☐ Date: _____

***If reporting Syphilis, please complete:***

**Previous diagnoses of Syphilis?** YES☐ NO☐ Date: _____

**Previous Treatment for Syphilis?** YES☐ NO☐ Date: _____

**Pending RPR/titer test results?** YES☐ NO☐ Date: _____

**Pending confirmatory test results?** YES☐ NO☐ Date: _____

## *TREATMENT*

### CHLAMYDIA
*ATTACH LAB*

**Treatment:**

☐ Azithromycin 1gm PO single dose
*Date of treatment:* _____

☐ Doxycycline 100mg PO BID x 7 days
*Date of treatment:* _____

☐ Levofloxacin 500mg PO q.d. x 7 days
*Date of treatment:* _____

☐ *Other TX:* _____

☐ *No treatment given for this infection*

☐ *Follow up Appointment:* _____

### GONORRHEA
*ATTACH LAB*

**Treatment:**

☐ Ceftriaxone 500mg IM single dose
*Date of Treatment:* _____

☐ Gentamicin 240mg IM single dose
**PLUS** Azithromycin 2gm PO x 1 dose
*Date of Treatment:* _____

☐ Cefixime 800mg PO single dose
*Date of treatment:* _____

☐ *Other TX:* _____

☐ *No treatment given for this infection*

☐ *Follow up appointment:* _____

### SYPHILIS
*ATTACH LAB*

**Treatment:**

Benzathine Penicillin G 2.4 MU IM
☐ Single dose. *Date:* _____
☐ 3 doses (given at one week interval)
*Date:* _____

Doxycycline 100mg PO given BID
☐ 14 days TX. *Date:* _____
☐ 28 days TX. *Date:* _____

☐ *Other TX:* _____

☐ *No treatment given for this infection*

☐ *Follow up appointment:* _____

FOR UPDATES AND COMPLETE TREATMENT GUIDELINES, PLEASE VISIT https://www.cdc.gov/std/treatment-guidelines