

Hudson Valley Regional Sexually Transmitted Infection (STI) Collaborative Reporting Form

Putnam County Department of Health | Phone: 845-808-1390 | FAX: 845-279-4104 | 1 Geneva Rd, Brewster, NY 10509 Rev. 10/2020

Last Name: _____ First Name: _____ Date of Birth: ___/___/___

Phone # _____ Address _____

Emergency Contact _____ Sex: Male Female Transgender - Male to Female / Female to Male

Race/Ethnicity: White Black Asian Other: _____ Unknown Hispanic Non-Hispanic

Marital Status: Single Married Divorced Separated Unknown Other: _____

Occupation: Unemployed Employed/Employer: _____ Sex of Partners: _____

Exam Date: ___/___/___ Screening Contact to STD Symptoms/Date of First Symptom ___/___/___

Discharge Lower Abdominal Pain Rash Bumps Itching
 Painful Urination Abnormal Bleeding Burning Sensation Testicular Pain Genital Warts
 Other _____

Pregnant No Yes

Outcome: Live/Due Date ___/___/___ Termination/Date ___/___/___ Miscarriage/Date ___/___/___ Unknown

Father of the Baby (FOB): _____ FOB Phone _____ EPT MDT

Was HIV test offered at this visit? Yes Yes, but patient declined No Unknown

Last known HIV test ___/___/___ On PrEP Referral for PrEP given ****Do NOT report HIV results on this form****

2010 NYS Law – Every person between the ages 13-64 should be offered an HIV test

CHLAMYDIA – MUST BE REPORTED WITHIN 5 DAYS OF POSITIVE LAB REPORT

Test Date: ___/___/___ Blood Cervical Urine Rectal Throat

Treatment Date ___/___/___ Expedited Partner Therapy No Med in Hand Rx Both Unknown

of Rx Given _____

Azithromycin (Zithromax) 1gm PO Single Dose **OR** Doxycycline (Vibramycin) 100mg PO 2x/day x 7 days Rx given

GONORRHEA – MUST BE REPORTED WITHIN 24 HOURS OF POSITIVE LAB REPORT

Test Date: ___/___/___ Blood Cervical Urine Rectal Throat

Treatment Date: ___/___/___ Rx. Given

Ceftriaxone (Rocephin) 250mg IM Single Dose AND Azithromycin (Zithromax) 1gm PO Single Dose (MUST be given at the same time)

Cefixime 400mg PO Single Dose AND Azithromycin (Zithromax) 1gm PO Single Dose (MUST have Test of Cure in 1 week)

SYPHILIS – MUST BE REPORTED WITHIN 24 HOURS OF POSITIVE LAB REPORT

Diagnosis Primary - Chancre Secondary – plantar palmer or bilateral body rash Early - No sx & new (+) test within a year

Benzathine Penicillin 2.4million units IM Single Dose Treatment Date: ___/___/___

Latent - Benzathine Penicillin 2.4million units IM X 3 Doses Treatment Date: ___/___/___

Test Date: ___/___/___ RPR _____

RPR Confirmed with TPPA - Reactive / Non-Reactive IgG/CIA/EIA – Reactive / Non-Reactive CSF – Reactive / Non-Reactive

Doxycycline (Vibramycin) 100mg PO 2x/day x 28 days (PCN Allergy)

Not Treated Previous hx of tx date: ___/___/___

*****FTA needs confirmation with TPPA or IgG*****

***** Titer Checks MUST be done to ensure successful treatment *****

Reporting Physician: _____

Date of Report: _____

Physician Address: _____

Telephone and Fax _____