CHLAMYDIA/GONORRHEA CASE REPORT

NORTH DAKOTA DEPARTMENT OF HEALTH
DISEASE CONTROL SECTION
SFN 61114 (02/2021)

The North Dakota Department of Health (NDDoH) Disease Control Section requires the following information to be reported on all chlamydia or gonorrhea cases. Please indicate which disease you are reporting (can be both):

Diagnosis Information

Reportable Condition: ☐ Chlamydia ☐ Gonorrhea	*Specimen Collection Date:*
Diagnosing HealthCare Provider:	
Facility:	*Telephone Number:*
Positive Specimen Source(s): ☐ Urine ☐ Cervix ☐ Rectum ☐ Pharyngeal	*Negative Specimen Source(s):* ☐ Urine ☐ Cervix ☐ Rectum ☐ Pharyngeal
Case Also Tested for: ☐ Chlamydia ☐ Gonorrhea	*Testing Laboratory:*

Required Patient Demographic Information

First Name:	*Last Name:*	*Date of Birth:*	
Street Address:	*City:*	*State:*	*ZIP Code:*
Telephone Number:	*Assigned sex at birth:* ☐ Male ☐ Female		
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Transgender Unspecified ☐ Another Gender ☐ Declined to Answer			
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused	*Ethnicity:* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused		
Pregnancy Status: ☐ Not Pregnant ☐ Pregnant ☐ NA	If Pregnant, Due Date:		
Was case tested for HIV? ☐ Yes ☐ No	If Yes: Collection Date:	Result: ☐ Positive ☐ Negative	
Was case tested for Syphilis? ☐ Yes ☐ No	If Yes: Collection Date:	Result: ☐ Positive ☐ Negative	

Clinical History

Reason Test Conducted: ☐ Infection ☐ Screen ☐ Partner Referral		
Were symptoms noted? ☐ Yes ☐ No	*If Yes, onset date:*	*Please note symptoms:*
Was PID diagnosed? ☐ Yes ☐ No		

Treatment Information

Was treatment given for this infection? ☐ Yes ☐ No	*Treatment Date:*
Chlamydia: ☐ 1g Azithromycin ☐ 100mg Doxycycline BID x 7 days	***Gonorrhea:*** ☐ 500mg IM Ceftriaxone ☐ 1g IM Ceftriaxone (if patient is >150kg (330lbs) ☐ 500mg Ceftriaxone & 100mg Doxycycline BID x 7 Days
PID: ☐ 250mg IM Ceftriaxone & 100mg Doxycycline BID x 14 days ☐ 2g IM Cefoxitin & 1g Oral Probenecid & 100mg Doxycycline BID x 14 days ☐ Other Parenteral Third-generation Cephalosporin & 100mg Doxycycline BID x 14 days	☐ 500 mg BID Metronidazole BID x 14 days (not required)
Alternate therapy?	
If not observed, what pharmacy was prescription sent to?	
Was follow up appointment made in 3 months to have a test for reinfection? ☐ Yes ☐ No	

Did the patient have or ever had any of the following risk factors?

Does the patient have a history of STI infections?	☐ Yes ☐ No
Is the patient resident/staff of correctional facility?	☐ Yes ☐ No
Has patient used intravenous/injection drugs?	☐ Yes ☐ No
Has patient used non-injection drugs?	☐ Yes ☐ No
Has the patient had sex while high/intoxicated?	☐ Yes ☐ No
Has the patient had sex with an injection drug user?	☐ Yes ☐ No
Has the patient traded sex for drugs or money?	☐ Yes ☐ No
Has the patient had sex with an anonymous sex partner?	☐ Yes ☐ No
Has the patient ever met sexual partners on the internet?	☐ Yes ☐ No
Total number of sex partners in last 12 months:	
*Number of **Female** Partners*	
*Number of **Male** Partners*	
*Number of **Transgender** Partners*	
What types of sex has the patient had?	☐ Oral, unspecified ☐ Oral, perform ☐ Oral, receive ☐ Vaginal ☐ Anal, unspecified ☐ Anal, top ☐ Anal, bottom
How frequently does the patient use condoms during sex?	☐ Always (100%) ☐ Most of the time (75%) ☐ Half the time (50%) ☐ Not that Often (25%) ☐ Never (0%)

Sex Partner History

Obtain Partner History for 60 days prior to diagnosis.

Partner Name:	*Date of Birth or Approximate Age:*	*Gender Identity:* ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender	
Address:	*City:*	*State:*	*Telephone Number:*
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		*Note for Exposure Dates: Include approximate dates if exact date unknown.*	
Was this partner contacted and referred for testing? ☐ Yes ☐ No		*Was partner treated?* ☐ Yes ☐ No	
Was this partner tested? ☐ Yes ☐ No		*Was partner treated via EPT?* ☐ Yes ☐ No	
Partner Specimen Collection Date:		*Partner Treatment Type:*	
Partner Results:		*Partner Treatment Date:*	

Sex Partner History *Duplicate Sex Partner History form for additional partners*

Obtain Partner History for 60 days prior to diagnosis.

Partner Name:	*Date of Birth or Approximate Age:*		*Gender Identity:* ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	*City:*	*State:*	*Telephone Number:*
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		*Note for Exposure Dates: Include approximate dates if exact date unknown.*	
Was this partner contacted and referred for testing? ☐ Yes ☐ No		*Was partner treated?* ☐ Yes ☐ No	
Was this partner tested? ☐ Yes ☐ No		*Was partner treated via EPT?* ☐ Yes ☐ No	
Partner Specimen Collection Date:		*Partner Treatment Type:*	
Partner Results:		*Partner Treatment Date:*	

Partner Name:	*Date of Birth or Approximate Age:*		*Gender Identity:* ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	*City:*	*State:*	*Telephone Number:*
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		*Note for Exposure Dates: Include approximate dates if exact date unknown.*	
Was this partner contacted and referred for testing? ☐ Yes ☐ No		*Was partner treated?* ☐ Yes ☐ No	
Was this partner tested? ☐ Yes ☐ No		*Was partner treated via EPT?* ☐ Yes ☐ No	
Partner Specimen Collection Date:		*Partner Treatment Type:*	
Partner Results:		*Partner Treatment Date:*	

Partner Name:	*Date of Birth or Approximate Age:*		*Gender Identity:* ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	*City:*	*State:*	*Telephone Number:*
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		*Note for Exposure Dates: Include approximate dates if exact date unknown.*	
Was this partner contacted and referred for testing? ☐ Yes ☐ No		*Was partner treated?* ☐ Yes ☐ No	
Was this partner tested? ☐ Yes ☐ No		*Was partner treated via EPT?* ☐ Yes ☐ No	
Partner Specimen Collection Date:		*Partner Treatment Type:*	
Partner Results:		*Partner Treatment Date:*	

Please Fax Completed Forms to 701.328.0355. Contact NDDoH at 701.328.2378 for any questions.

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