

Fax or Mail Completed Form to:

STD Program Manager
 615 East 4th St Pierre, SD 57501
 Phone: 605-773-4794
 Fax: 605-773-5509

STD CASE REPORT AND INTERVIEW FORM

Office of Disease Prevention

**For Clinic / Provider Use Only**

Patient / Chart ID: _____

Original Report: _____ Follow up: _____

CLIENT INFORMATION

Last Name: _____ **First Name:** _____ **AKA:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

County: _____ **Phone:** (Home) () _____ - _____

(Work) () _____ - _____ (Cell) () _____ - _____ (Other) () _____ - _____

Date of Birth: ____ / ____ / ____ **Current Gender:** _____ **Gender at Birth:** _____

Race: White Black / African American Asian / Pacific Islander American Indian / Alaska Native Other

Ethnicity: Hispanic Non-Hispanic

Comments: _____

CLINICAL INFORMATION

Chlamydia: _____ **Gonorrhea:** _____ **Reporting Facility:** _____

Specimen Collection Date: ____ / ____ / ____ **Physician:** _____

Symptomatic: No Yes **Duration:** _____

Pregnant: No Yes **If yes, how many weeks?** _____

X	MEDICATION ADMINISTERED	DATE
	Azythromycin (Zithromax), P.O., 1 gm x 1	
	Ceftriaxone (Rocephin), I.M., 250 mg x 1	
	Cefixime (Suprax), P.O., 400 mg x 1	
	Doxycycline, P.O., 100 mg BID x 7 days	
	Other:	

ADDITIONAL CLIENT INFORMATION

Estimated Date of Last Sexual Exposure: ____ / ____ / ____

Tested for HIV?: No Yes **Date:** ____ / ____ / ____ **Results:** _____

Other (condoms provided, handouts, referrals, etc.): _____

Please complete partner information on the back of this page.

List sexual partners in the past two months. If none, list last partner.

If a partner tests positive at your facility, please complete a new HS-417 form so clinical information can be obtained.

Original Patient: Last Name _____ First Name: _____

PARTNER INFORMATION

Estimated Date of Last Exposure: ____ / ____ / ____

Last Name: _____ First Name: _____ AKA: _____

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

County: _____ Phone: (Home) () _____ - _____ (Cell) () _____ - _____

(Work) () _____ - _____ (Other) () _____ - _____ Date of Birth: ____ / ____ / ____

Estimated Age: _____ Current Gender: ____ Gender at Birth: ____ Ethnicity: Hispanic Non-Hispanic

Race: White Black / African American Asian / Pacific Islander American Indian / Alaska Native Other

Notes (employer, school, jail, etc.): _____

Attempts to contact: _____

Did this partner: present to your facility for follow-up? No Yes receive Partner Delivered Therapy (PDT)? No Yes

Tested?: No Yes Results: _____ Date: ____ / ____ / ____

Treated?: No Yes Dosage: _____ Date: ____ / ____ / ____

This partner notified of STD exposure by patient: No Yes This partner notified of STD exposure by clinic: No Yes

PARTNER INFORMATION

Estimated Date of Last Exposure: ____ / ____ / ____

Last Name: _____ First Name: _____ AKA: _____

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

County: _____ Phone: (Home) () _____ - _____ (Cell) () _____ - _____

(Work) () _____ - _____ (Other) () _____ - _____ Date of Birth: ____ / ____ / ____

Estimated Age: _____ Current Gender: ____ Gender at Birth: ____ Ethnicity: Hispanic Non-Hispanic

Race: White Black / African American Asian / Pacific Islander American Indian / Alaska Native Other

Notes (employer, school, jail, etc.): _____

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Tested?: No Yes Results: _____ Date: ____ / ____ / ____

Treated?: No Yes Dosage: _____ Date: ____ / ____ / ____

This partner notified of STD exposure by patient: No Yes This partner notified of STD exposure by clinic: No Yes

PARTNER INFORMATION

Estimated Date of Last Exposure: ____ / ____ / ____

Last Name: _____ First Name: _____ AKA: _____

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

County: _____ Phone: (Home) () _____ - _____ (Cell) () _____ - _____

(Work) () _____ - _____ (Other) () _____ - _____ Date of Birth: ____ / ____ / ____

Estimated Age: _____ Current Gender: ____ Gender at Birth: ____ Ethnicity: Hispanic Non-Hispanic

Race: White Black / African American Asian / Pacific Islander American Indian / Alaska Native Other

Notes (employer, school, jail, etc.): _____

Attempts to Contact: _____

Did this partner: present to your facility for follow-up? No Yes receive Partner Delivered Therapy (PDT)? No Yes

Tested?: No Yes Results: _____ Date: ____ / ____ / ____

Treated?: No Yes Dosage: _____ Date: ____ / ____ / ____

This partner notified of STD exposure by patient: No Yes This partner notified of STD exposure by clinic: No Yes