



Phone: 1 (888) 374-8824 Confidential Fax: (801) 538-9923 Email: reporting@utah.gov

Chlamydia and gonorrhea case report form

Instructions

Complete all sections of this form using available data and fax or email* the completed form to Utah public health. As chlamydia and gonorrhea are reportable diseases, client consent to release this information to Utah public health is ***not required*** and disease reporting is mandatory per Utah State Health Code 26-6-6.

*case reports submitted via email need to be sent securely via an encryption service such as Virtru.

Demographic information

Last name:	First name:	MI:
Address:	City:	
State:	County:	ZIP:
Phone #1:	Phone #2:	Phone #3:
Date of birth: ___/___/___	Age:	Birth sex: (check one) <input type="checkbox"/> M <input type="checkbox"/> F
Current gender: (check one) <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Non-binary <input type="checkbox"/> Other, specify: _____		
Race: (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Primary language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other, specify: _____		

Treatment information

See [CDC STI Treatment Guidelines, 2021](#) for complete treatment guidelines including alternate treatment regimens. Please note that these guidelines were updated on July 22, 2021

Chlamydia treatment

- Doxycycline 100 mg orally BID x 7 days Treatment date: ___/___/___
- Azithromycin 1 g orally in a single dose
- Other, specify: _____

Gonorrhea treatment

- Ceftriaxone 500 mg IM in a single dose Treatment date: ___/___/___
- Cefixime 800 mg orally in a single dose*
- Other, specify: _____

Laboratory information	
Attach a copy of the lab results	
Reporting	
Reporter's name: _____	Phone number: _____
Reporter's agency: _____	Date reported to public health: ___/___/___
Clinical information	
Clinician name: _____	Clinician phone #: (____) ____ - _____
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	
Date of last HIV test: ___/___/___	Test result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Equivocal <input type="checkbox"/> Unknown
Is the patient MSM (a man who has sex with men): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	
Expedited partner therapy	
<p><u>Expedited partner therapy</u> (EPT) enables providers to treat the sexual partners of patients diagnosed with chlamydia or gonorrhea by giving a prescription or medication to the patient to take to their partner(s).</p> <p><i>*EPT is not recommended for partners who have had an oral exposure to gonorrhea, as oral treatment is less effective at eradicating pharyngeal gonorrhea than IM ceftriaxone. Clinicians should use shared decision-making when considering offering EPT to MSM due to high rates of comorbidities in this population.</i></p>	
<p>Was EPT provided to any of the patient's partners? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many partners were treated with EPT? _____</p> <p><i>Record the treatment given in the partners section. For unknown partners, put first and last names as unknown and fill in any information about them you may have (e.g., phone number).</i></p>	
Contact management	
<p><i>Complete the following information for all partners the patient has had sexual contact with in the last 90 days.</i></p>	
Name: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB / age: _____
Address: _____	Phone: (____) ____ - _____
Treatment provided: _____	Was this treatment EPT? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last sexual encounter: ___/___/___	

Chlamydia and gonorrhoea

Patient name: _____

Name: _____ Sex: M F DOB / age: _____
Address: _____ Phone: (____) _____ - _____
Treatment provided: _____ Was this treatment EPT? Yes No
Date of last sexual encounter: ____/____/____

Name: _____ Sex: M F DOB / age: _____
Address: _____ Phone: (____) _____ - _____
Treatment provided: _____ Was this treatment EPT? Yes No
Date of last sexual encounter: ____/____/____

Name: _____ Sex: M F DOB / age: _____
Address: _____ Phone: (____) _____ - _____
Treatment provided: _____ Was this treatment EPT? Yes No
Date of last sexual encounter: ____/____/____

Name: _____ Sex: M F DOB / age: _____
Address: _____ Phone: (____) _____ - _____
Treatment provided: _____ Was this treatment EPT? Yes No
Date of last sexual encounter: ____/____/____

Name: _____ Sex: M F DOB / age: _____
Address: _____ Phone: (____) _____ - _____
Treatment provided: _____ Was this treatment EPT? Yes No
Date of last sexual encounter: ____/____/____