



FLORIDA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES

STD Surveillance

"Protecting Your Health...It's what we do"

407 836-2600 Fax: 407 836-7101
Lisa x 78114 Wilma x 78043
Valerie 407 836-2646
Viola 407 836-9251

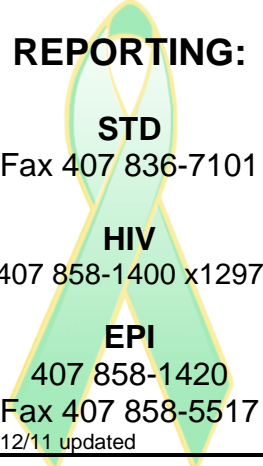
832 W. Central Blvd.
Orlando, FL 32805
www.orchd.com

Female _____ Male _____
Not Pregnant _____ Pregnant _____
Pregnancy due date _____

Patient Name: _____
DOB: _____
SS#: _____
Address: _____
Phone: _____

RACE: WHITE BLACK HISP NON-HISP OTHER AM INDIAN/ALASKAN ASIAN/PAC ISLANDER

All diseases listed below must be reported to OCHD/STD W/TX the next bus day

CHLAMYDIA	GONORRHEA	SYPHILIS	OTHER
<input type="checkbox"/> Uncomplicated <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Pelvic Inflammatory Disease (PID) <input type="checkbox"/> Pneumonia <div style="border: 1px solid black; padding: 5px; width: fit-content;"> VISIT OUR WEBSITE FOR AN ELECTRONIC COPY OF OUR REPORTING FORM </div>	<input type="checkbox"/> Uncomplicated <input type="checkbox"/> Disseminated Gonococcal <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Oral/Pharyngeal <input type="checkbox"/> Other resistant strain <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Penicillinase-Producing Neisseria Gonorrhoea (PPNG) <input type="checkbox"/> Rectal †Treatment for Pharyngeal = Ceftriaxone 250 IM	<input type="checkbox"/> RPR 1: _____ Types of Confirmatory test <input type="checkbox"/> TP-PA positive <input type="checkbox"/> FTA-ABS positive <input type="checkbox"/> IgG-EIA positive <input type="checkbox"/> MHA-TP positive Diagnosis <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Early Latent (< 1 yr) <input type="checkbox"/> Late Latent <input type="checkbox"/> Tertiary <input type="checkbox"/> Congenital	REPORTING:  STD Fax 407 836-7101 HIV 407 858-1400 x1297 EPI 407 858-1420 Fax 407 858-5517 <small>1/12/11 updated</small>
Collection date	Collection date	Collection date	
Reporting laboratory	Reporting laboratory	Reporting laboratory	
Treatment date _____ * CDC Recommended Regimen <input type="checkbox"/> Azithromycin 1 gm * <input type="checkbox"/> Doxycycline 100 mg BID x 7 Days * <input type="checkbox"/> Levofloxacin 500 mg x 7 Days <input type="checkbox"/> Ofloxacin 300 mg BID x 7 Days <input type="checkbox"/> Amoxicillin 500 mg TID x 7 Days <input type="checkbox"/> Erythromycin base 500 QID x 7 Days IF PREGNANT <input type="checkbox"/> Azithromycin 1 gm * <input type="checkbox"/> Erythromycin base 500 QID x 7 Days <input type="checkbox"/> Amoxicillin 500 TID x 7 Days Any tx used other than recommended treatment will need a TOC 3 weeks after completion of therapy. TOC less than 3 wks could yield false positive results.	Treatment date _____ * CDC Recommended Regimen <input type="checkbox"/> Ceftriaxone 250 mg IM * <input type="checkbox"/> Cefprozime 500 IM <input type="checkbox"/> Cefotaxime 500 IM <input type="checkbox"/> Cefixime 400 mg <input type="checkbox"/> Vantin (Cefpodoxime) 400 mg <input type="checkbox"/> Cefuroxime 1 gm IF PREGNANT <input type="checkbox"/> Ceftriaxone 250 mg IM * <input type="checkbox"/> Cefixime 400 mg <input type="checkbox"/> AZ 2 gm Any tx used other than recommended treatment will need a TOC 3 weeks after completion of therapy. TOC less than 3 wks could yield false positive results.	Treatment dates: 2.4 BIC #1 _____ 2.4 BIC #2 _____ 2.4 BIC #3 _____ <input type="checkbox"/> Doxycycline 100 BID x 14 days Date _____ <input type="checkbox"/> Doxycycline 100 QID x 28 days Date _____	

PROVIDER INFORMATION

Practice Name _____
Address _____
Area code & phone _____