TEXAS DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED INFECTIONS (STI)

All providers who diagnose or treat a reportable sexually transmitted infection are required to report to the local health authority within seven (7) days. Complete all spaces or check all boxes as appropriate. Shaded areas are not required by law, but necessary for appropriate identification or follow up.

Patient's Name (Last, First, MI.)	**Date of Birth**	**Age**	**Sex** M ☐ F ☐	**Pregnant?** N ☐ Y ☐ ___# of weeks
Address (Street, City, State, Zip)	**Hispanic Ethnicity** Yes ☐ No ☐		Race *check all that apply* W ☐ B ☐ AIS ☐ AI ☐ PI ☐	
Telephone:	**Marital Status** S ☐ M ☐ W ☐ D ☐	**Employment**	**Sex of Partners:** F ☐ M ☐ Both ☐	**SSN/Medical record No.**

Provider Type: ☐ Private Phy/Primary Care ☐ Family Planning ☐ Prenatal/OB clinic ☐ Other clinic ☐ Hospital ☐ Emergency ☐ HIV Site ☐ STD Clinic ☐ Drug Treatment ☐ TB clinic ☐ Correctional Facility ☐ Laboratory ☐ Blood/Plasma ☐ Other

Exam Date: **Exam Reason**: ☐ Volunteer ☐ Referred by Partner ☐ Referred by another provider ☐ DIS Partner Referral ☐ DIS Suspect Referral ☐ Prenatal ☐ Delivery ☐ Screening in Jail/Prison ☐ Other screening

100 Chancroid

Treatment Date:
Treatment Given:
☐ Azithromycin
☐ Ceftriaxone
☐ Other:

Dosage:
☐ 1 gram
☐ 250 mg IM
☐ Other:

☐ No Treatment Given

200 Chlamydia (Not PID)
☐ Urethral
☐ Vaginal
☐ Cervical
☐ Rectal
☐ Pharyngeal
☐ Ophthalmia

Type of Test:
Treatment Date:
Treatment Given:
☐ Azithromycin
☐ Doxycycline
☐ Other:

Dosage:
☐ 1 gram
☐ 100 mg BID X 7 days
☐ Other:

☐ No Treatment Given

300 Gonorrhea (Not PID)
☐ Urethral
☐ Vaginal
☐ Cervical
☐ Rectal
☐ Pharyngeal
☐ Ophthalmia
☐ Resistant GC

Type of Test:
Treatment Date:
Treatment Given:
☐ Ceftriaxone
☐ Other:

Dosage:
☐ 500 mg IM
☐ Other:

☐ No Treatment Given

490 Pelvic Inflammatory Disease
Disease:
☐ Chlamydial
☐ Gonoccocal
☐ Other or Unknown Etiology

Type of Test:
Treatment Date:
Treatment Given:
☐ Ceftriaxone
☐ Doxycycline
☐ Metronidazole
☐ Other:

Dosage:
☐ 500 mg IM
☐ 100 mg BID X 14 days
☐ 500 mg BID X 14 days
☐ Other:

☐ No Treatment Given

600 Lymphogranuloma Venereum (LGV) ☐

Treatment Date:
Treatment Given:
☐ Doxycycline
☐ Other:

Dosage:
☐ 100 mg BID X 21 days
☐ Other:

☐ No Treatment Given

700 Syphilis
☐ Primary (lesions)*** report within 24 hrs**
☐ Secondary (symptoms) ***report within 24 hrs**
☐ Early Latent (< 1 year)
☐ Late Latent (> 1 year)
☐ Late (with symptoms)
☐ Congenital Syphilis

Y N Unk
☐ ☐ ☐ Neurologic Involvement

Type of Test:
Treatment Date(s):

Treatment Given:
☐ Benzathine penicillin G
☐ Doxycycline
☐ Other:

Dosage:
☐ 2.4 mu IM X 1
☐ 2.4 mu IM X 3
☐ 100 mg BID X ☐ 14 days ☐ 28 days
☐ Other:
☐ No Treatment Given

900
☐ **HIV Non- AIDS**
☐ **HIV with AIDS**
☐ **Non-Reactive HIV Test Results**

Type of Test:

Date of Result:

Reporting HIV on this document serves as proof of timely report; however, the health department requires additional information on HIV patients.

Reporting Address:

(Local Health Authority place mailing information here)

Reported By:

Name Office Address City Phone Number

STD-27 (Rev 11/2022)

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Use the spaces below to report your patient's sexual or needle sharing partner(s) for confidential notification by a Disease Intervention Specialist (DIS). When those listed below are notified of exposure, the DIS will not reveal your patient's identity.

Please consult me or my designated staff before contacting my patient: ☐

Designated Staff Person:	**Telephone:**	**Extension:**	**Best time to call me or my staff:**

Partner's Name (Last, First, MI.)	Nickname or alias:	Hispanic Ethnicity Yes ☐ No ☐	Race	Sex	DOB or approximate age

Partner's Address (Street, Apartment, City, State)	Telephone: Home: Work:	Best time to call or visit partner:

Date of last exposure to patient: Partner's Marital Status: S ☐ M ☐ W ☐ D ☐ Partner's Place of Employment: Work Hours:	Treatment given: Date:

Partner's Name (Last, First, MI.)	Nickname or alias:	Hispanic Ethnicity Yes ☐ No ☐	Race	Sex	DOB or approximate age

Partner's Address (Street, Apartment, City, State)	Telephone: Home: Work:	Best time to call or visit partner:

Date of last exposure to patient: Partner's Marital Status: S ☐ M ☐ W ☐ D ☐ Partner's Place of Employment: Work Hours:	Treatment given: Date:

Partner's Name (Last, First, MI.)	Nickname or alias:	Hispanic Ethnicity Yes ☐ No ☐	Race	Sex	DOB or approximate age

Partner's Address (Street, Apartment, City, State)	Telephone: Home: Work:	Best time to call or visit partner:

Date of last exposure to patient: Partner's Marital Status: S ☐ M ☐ W ☐ D ☐ Partner's Place of Employment: Work Hours:	Treatment given: Date:

Fax to Texas Department of State Health Services Region 2/3 DIS @ 817-264-4778