Reset Form

INDIANA CONFIDENTIAL SEXUALLY TRANSMITTED INFECTION (STI) REPORTING

State Form 56459 (R2/ 6-25)

Indiana Department of Health

PATIENT INFORMATION

Legal Last Name: _____ **Legal First Name:** _____ **MI:** ____

Preferred Name (*if different than legal name*):_____ **Date of Birth:** ____/____/____

Address ***(number and street)*:** _____

City/State/ZIP:_____ **County:** _____

Telephone: _____ ☐ Home ☐ Work ☐ Cell

Sex: ☐ Male ☐ Female ☐ Unknown **Pregnant**: ☐ Yes ☐ No

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ Other ☐ Multiracial ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Health Insurance:** ☐ Yes ☐ No **Marital Status:** ☐ Single ☐ Married

******For reports of positive chlamydia, gonorrhea, and syphilis cases only.******

Check all that apply: ☐ **CHLAMYDIA** ☐ **GONORRHEA:**

☐ Pelvic Inflammatory Disease **Specimen Source:** **Collection Date:** ____/____/____

☐ Cervix ☐ Patient-collected vaginal **Test Type:** _____

☐ Urethral ☐ Urine ☐ Rectal ☐ Pharyngeal

Treatment:

☐ Prescribed ☐ Administered ☐ Patient Not Treated ☐ Patient Not Informed of Result **Date:** ____/____/____

Treatment Regimen *(including dosage)*:

_____

Does patient have sex with: ☐ Men ☐ Women ☐ Both ☐ Unknown

Were patient's partners notified of exposure? ☐ Yes, by our office. ☐ Yes, patient notified partners. ☐ No ☐ Unknown

Treatment given for patient's partners? ☐ Yes, extra medication given for ___ (#) partners. ☐ Yes, prescription written for ___ (#) partners. ☐ No

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SYPHILIS: ***Please report all positive test results and negative reflex test results.***

☐ Primary ☐ Secondary ☐ Early (less than 12 months duration) ☐ Late (greater than 12 months duration) ☐ Congenital ☐ Unknown

Collection date: ____/____/____ **Symptoms:** _____

Onset Date: ____/____/____ ☐ Neurologic symptoms? ☐ Ocular symptoms? ☐ Otic symptoms?

Non-Treponemal Tests: **Treponemal Tests:**

☐ RPR ☐ VDRL ☐ CSF-VDRL EIA IgG: ☐ Positive ☐ Negative FTA: ☐ Positive ☐ Negative

☐ Positive ☐ Negative Titer: 1:___ TPPA: ☐ Positive ☐ Negative Other *(specify)*:_____ Result: _____

Treatment:

☐ Prescribed ☐ Administered ☐ Patient Not Treated ☐ Patient Not Informed of Result **Date:** ____/____/____

Treatment Regimen *(including dosage)*:

_____

Does patient have sex with: ☐ Men ☐ Women ☐ Both ☐ Unknown

Were patient's partners notified of exposure? ☐ Yes, by our office. ☐ Yes, patient notified partners. ☐ No ☐ Unknown

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Ordering Provider: _____ **Provider Facility:** _____ **Telephone**:_____

Person Completing Form: _____ **Date of Report:** ____/____/____

Name: _____

Fax: _____

Contact Telephone: _____

All reports of sexually transmitted disease must be made within seventy-two (72) hours of diagnosis. Please fax form to district STD reporting facility. Find the current contact information by downloading the most current DIS Contact Map which can be found at https://www.in.gov/health/hiv-std-viral-hepatitis/std-surveillance//. Contains confidential information per 410 IAC 1-2.5-78.