

MINNESOTA CONFIDENTIAL CHLAMYDIA AND GONORRHEA REPORT FORM

PATIENT INFORMATION

Patient last name:

Medical record number:

Patient first name:

M.I.:

Date of birth: (MM-DD-YYYY)

Patient street address:

Apt/unit #:

City/town:

State:

Zip:

☐ Homeless

☐ Address unknown

Gender:

- ☐ Male ☐ Transgender (M to F)
☐ Female ☐ Transgender (F to M)

Race (mark all that apply):

- ☐ American Indian/Alaska Native
☐ Asian/Asian American
☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Other: _____
☐ Unknown

Phone:

☐ Home

☐ Work

☐ Mobile/cell

Did the patient exhibit signs/symptoms at time of test?

☐ Yes

☐ No

☐ Unknown

Pregnant:

☐ No ☐ Unknown

☐ Yes # weeks: _____

HIV tested at this visit:

☐ Yes ☐ No

☐ Previous positive

Due date:

Patient on PrEP?

☐ Yes ☐ No

CHLAMYDIA (CT) - LAB CONFIRMED

Specimen collection date:

Source (mark all that apply):

- ☐ Cervix ☐ Rectum
☐ Vagina ☐ Pharynx
☐ Urethra ☐ Urine
☐ Other: _____

EPT Given?:

☐ Yes ☐ No

Treatment date:

- ☐ Doxycycline 100 mg po BID x 7 days ☐ Not treated for chlamydia

Alternative regimens:

- ☐ Azithromycin (Zithromax) 1 g po x 1
☐ Levofloxacin 500 mg po x 7 days
☐ Other: _____

GONORRHEA (GC) - LAB CONFIRMED

Specimen collection date:

Source (mark all that apply):

- ☐ Cervix ☐ Rectum
☐ Vagina ☐ Pharynx
☐ Urethra ☐ Urine
☐ Other: _____

To report disseminated gonorrhea or concern over persistent infection call: 651-201-5414.

EPT Given?:

☐ Yes ☐ No

Treatment date:

- ☐ Ceftriaxone (Rocephin) 500 mg IM x 1 (For persons weighing <150 kg*) ☐ Not treated for gonorrhea

- ☐ Ceftriaxone (Rocephin) 1 g IM x 1 (For person weighing ≥150 kg*)

Alternative regimens:

- ☐ Cefixime (Suprax) 800 mg po x 1*
☐ Gentamicin 240 mg IM x 1 plus Azithromycin (Zithromax) 2 g po x 1
☐ Other: _____

*If chlamydial infection has not been excluded, providers should treat for chlamydia with doxycycline 100 mg orally twice daily for 7 days (Doxycycline 100 mg po BID x 7 days). During pregnancy, azithromycin 1 g as a single dose is recommended to treat chlamydia (Azithromycin (Zithromax) 1 g po x 1).

DIAGNOSIS INFORMATION

PROVIDER INFORMATION

Diagnosed by:

Reported by (if different from diagnosed by):

Facility/clinic name:

Office telephone:

Facility/clinic address:

Office fax:

City:

State:

Zip: