Louisiana Department of Health Confidential Report of Sexually Transmitted Diseases (STD)

Mail to: Louisiana Department of Health-STD/HIV/Hepatitis Program, PO Box 60630, New Orleans, LA 70160 or FAX to: (504) 568-8384

Date Reported:

Name of Provider: | **Facility/Clinic Name:** | **Phone #:**

City: | **State:** | **Zip Code:**

PATIENT INFORMATION | **Last Name:** | **First Name:** | **MI:**

Medical Rec. No:

DOB (MM/DD/YYYY): | **SSN #:** | **Marital Status:** ☐ Single ☐ Married ☐ Divorce ☐ Separated

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

Sex at Birth: ☐ Female ☐ Male

Gender: ☐ Female ☐ Male ☐ Transgender Male-to-Female ☐ Transgender Female-to Male

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Pregnant? ☐ Yes ☐ No ☐ Unknown Expected Delivery Date: ____/____/____

Address: | **City:** | **State:** | **Zip Code:**

Cell Phone: ( ) - | **Alt. Phone: ( ) -** | **Pt. Email:**

Gender of Sex Partner(s): ☐ Female ☐ Male ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Unknown

LABORATORY NAME:

CHLAMYDIA

Date of Specimen Collection:

☐ Urogenital (Urine, cervical, etc.)
☐ Oral/ Pharyngeal
☐ Rectal
☐ Ophthalmia neonatorum
☐ Proctitis
☐ Pelvic Inflammatory Disease (PID)
☐ Pneumonia
☐ Lymphogranuloma Venereum (LGV)
☐ Other (specify): _____

Test Type:

☐ Culture
☐ NAAT
☐ Nucleic Acid Probe
☐ Point of Care Test
☐ Other (specify): _____

Date Treatment Administered or Prescription Given:

Unknown

☐ Doxycycline 100mg orally 2 times/day for 7days

Alternative Treatment:

☐ Azithromycin 1 gm orally in a single dose
OR
☐ Levofloxacin 500 mg orally once daily for 7 days.

During pregnancy

☐ Azithromycin 1 g orally in a single dose.

Alternative:

☐ Amoxicillin 500 mg orally 3 times/day for 7 days.
☐ Other (specify): _____

GONORRHEA

Date of Specimen Collection:

☐ Urogenital (Urine, cervical, etc.)
☐ Oral/Pharyngeal
☐ Rectal
☐ Disseminated Gonococcal Infection DGI)
☐ Ophthalmia neonatorum
☐ Resistant Strain
☐ Proctitis
☐ Pelvic Inflammatory Disease (PID)
☐ Other (specify): _____

Test Type:

☐ Culture
☐ NAAT
☐ Nucleic Acid Probe
☐ Point of Care Test
☐ Other (specify): _____

Date Treatment Administered or Prescription Given:

Unknown

☐ Ceftriaxone 500mg IM single dose for persons weighing <150 kg (300 lb).
☐ Persons weighing ≥150 kg (300 lb), 1 g of IM ceftriaxone.

Alternative Treatment if above Rx is not available:

☐ Gentamicin 240mg IM in a single dose **PLUS** Azithromycin 2g orally in a single dose **OR**
☐ Cefixime 800 mg orally in a single dose.
☐ Other (specify): _____

SYPHILIS

Date of Specimen Collection:

☐ Primary (Genital or oral ulcer)
☐ Secondary (Rashes/condyloma lata)
☐ Early non-primary non-secondary
☐ Unknown duration or Late syphilis
☐ Tertiary - Cardiovascular
☐ Tertiary - Neurosyphilis
☐ Ocular syphilis
☐ Otosyphilis
☐ Congenital
☐ Other (specify):_____

Test(s) Conducted & Results:

☐ RPR Titer _____
☐ VDRL Titer _____
☐ MHA-TP _____
☐ FTA _____
☐ IgG (EIA) _____
☐ TP-PA _____
☐ Point of Care Test
☐ Other _____

Date Treatment Administered: Unknown

☐ 2.4 million units Benzathine Penicillin G (BIC) IM X 1 dose.

Date 1st Dose Administered: _____/_____/_____

☐ 2.4 million units Benzathine Penicillin G (BIC) IM X 3 doses.

Alternate Treatment:

☐ Doxycycline 100 mg orally twice a day for 14 days
☐ Doxycycline 100 mg orally twice a day for 28 days
☐ Other (specify): _____

OTHER

Date of Specimen Collection:

_____/_____/_____

☐ Herpes Simplex Virus (Neonates)
☐ Other (specify): _____

Test(s) Conducted & Results:

☐ _____
☐ _____
☐ _____

Treatment:

☐ _____
☐ _____

For more information, call (504) 568-7474 or go to http://www.LAHHUB.org (Form: STD 43 Rev 9/30/21)

LOUISIANA DEPARTMENT OF HEALTH CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED INFECTIONS (STD)

DESCRIPTION & PURPOSE
The STD 43 is a single page form to report newly diagnosed, re-infected, and treated STDs with the exception of HIV/AIDS.

Directions for reporting HIV/AIDS cases contact: Submit the appropriate HIV Reporting form to the STD/HIV/Hepatitis Program, 1450 Poydras Street Suite 2136, New Orleans, LA 70112 or call (504) 568-7474. For additional information about HIV Surveillance, go to: http://www.LAHHUB.org

INSTRUCTIONS FOR COMPLETING the STD 43:
Use one (1) form per person to report all applicable STDs. *PLEASE Print legibly.*

Provider Information: Write the Date the Report will be submitted, Provider Name Reporting, Provider Address, and Phone number in the boxes or place designated or a typed label with the same information over the box. If provider and facility are different, provide information for both. Services provided via the internet must list a valid medical provider and facility name.

Patient Information: Write the medical record #, Last Name/First Name/Middle Initial, Date of Birth (DOB), Social Security Number (SSN), in the spaces provided. Check the appropriate box (es) for Marital status, Race, Sex at Birth, Gender, Ethnicity, Pregnancy status, Address, City/State/Zip Code, Phone number(s) and Email. Also check the appropriate box for Gender of Sex Partner(s).

Laboratory: Write the Name of the laboratory where the tests were conducted.

Disease: Check appropriate box (es) in this section depending on the diagnosis. In addition to completing the form, call the STD/HIV/Hepatitis Program at (504)568-7474 to report all cases of infectious syphilis such as primary & secondary syphilis, per the states reporting requirements.

For each disease reported complete each box in the appropriate column including:
1. Check the box (es) for the disease(s) being reported
2. Write the *date laboratory specimens were collected*
3. Check the box (es) for *type of test*(s) conducted that were positive. Syphilis test(s) conducted must be reported with results to identify new cases, include *titers*:
   - If RPR/VDRL is positive and confirmatory test (e.g., TPPA or lgG-EIA) is negative, report NEGATIVE confirmatory test result also (to validate biological false positives).
   - Enter titer result for the RPR and/or VDRL test (e.g., RPR 1:16, VDRL 1:128).
   - Report non-reactive/negative RPR/VDRL result if confirmatory test is positive (i.e. TPPA, lgG-EIA, FTA, etc.)
4. Write / check box (es) of medication given; write *date treatment was administered* and *prescription was provided*

Important Note:
Form STD 43 should be mailed to the STD/HIV/Hepatitis Program as soon as the diagnosis is made. The form may be filled before treatment is completed. Patients should not be reported as cases unless the diagnosis is confirmed by appropriate positive tests. All contacts of STDs should be tested for the disease(s) to which they were exposed. If contacts are treated in the absence of positive laboratory tests, then they are considered epidemiologically treated. Epidemiologic treatment is applicable only to persons exposed to known STD cases. Therefore, the term does not apply to persons who are treated for symptoms only and are not, therefore, definitively diagnosed. Reporting of epidemiologic treatment should be withheld and reported only with positive laboratory tests or in priority cases investigated by the Louisiana Department of Health-Office of Public Health STD/HIV/Hepatitis Disease Intervention Specialist(DIS).

MAIL or FAX FORM
Mail to:
LOUISIANA DEPARTMENT OF HEALTH- STD/HIV/Hepatitis Program
1450 Poydras Street Suite 2136
New Orleans, LA 70112

Or

PO BOX 60630
NEW ORLEANS LA 70160

FAX to: (504)568-8384

For questions contact the STD/HIV/Hepatitis Program at: 504-568-7474 or visit our web site at: http://www.LAHHUB.org.
Thank you for reporting and supporting the control and prevention efforts of Sexually Transmitted Infections and Disease in Louisiana.