

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

PROVIDER INFORMATION

Name of Provider:		Phone: () -	Fax Number: () -
Facility Name:		Email:	
Address:	City:	State:	Zip
Name of Person Reporting:		Position:	

PATIENT INFORMATION

Patient Medical Rec. #:		Insurance : <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Unknown <input type="checkbox"/> None	
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip
Patient Hm Ph: () -	Patient Wk Ph: () -	Patient Cell Ph: () -	
DOB (MM/DD/YYYY) / /	SSN: - -	Emergency Contact:	
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male-to-Female <input type="checkbox"/> Transgender Female-to-Male	Pregnant: <input type="checkbox"/> Yes, Expected Delivery Date: / / <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other/Unknown			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Gender of Partner(s): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male-to-Female <input type="checkbox"/> Transgender Female-to-Male <input type="checkbox"/> Unknown			

CHLAMYDIA	<input type="checkbox"/> Urogenital (Urine, cervical, etc.) <input type="checkbox"/> Oral/ Pharyngeal <input type="checkbox"/> Rectal <input type="checkbox"/> Ophthalmia neonatorum <input type="checkbox"/> Proctitis <input type="checkbox"/> Pelvic Inflammatory Disease (PID) <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other (specify): _____	Test(s)Conducted: <input type="checkbox"/> Culture <input type="checkbox"/> NAAT <input type="checkbox"/> Nucleic Acid Probe <input type="checkbox"/> Point of Care Test <input type="checkbox"/> Other (specify): _____ Date Treatment Administered: ____/____/____ Date of prescription given: ____/____/____	Recommended Treatment: <input type="checkbox"/> Azithromycin 1g orally in a single dose OR Doxycycline 100 orally 2x/day for 7 days Alternative: <input type="checkbox"/> Erythromycin base 500 mg orally 4x/day for 7days OR Erythromycin ethylsuccinate 800 mg orally 4x/day for 7days OR Levofloxacin 500 mg orally 1x/day for 7 days OR Ofloxacin 300mg orally 2x/day for 7 days If Pregnant : <input type="checkbox"/> Azithromycin 1 g orally in a single dose <input type="checkbox"/> Amoxicillin 500 mg orally 3x/day for 7 days OR Erythromycin base 500mg orally 4x/day for 7 days OR Erythromycin base 250 mg orally 4x/day for 14 days OR Erythromycin ethylsuccinate 800 mg orally 4x/day for 7 days OR Erythromycin ethylsuccinate 800 mg orally 4x/day for 14 days
	Date of Specimen Collection: ____/____/____ Name of Testing Laboratory:		

GONORRHEA	<input type="checkbox"/> Urogenital (Urine, cervical, etc.) <input type="checkbox"/> Oral/Pharyngeal <input type="checkbox"/> Rectal <input type="checkbox"/> Disseminated Gonococcal Infection (DGI) <input type="checkbox"/> Ophthalmia neonatorum <input type="checkbox"/> Resistant Strain <input type="checkbox"/> Proctitis <input type="checkbox"/> Pelvic Inflammatory Disease (PID) <input type="checkbox"/> Other (specify): _____	Test(s)Conducted: <input type="checkbox"/> Culture <input type="checkbox"/> NAAT <input type="checkbox"/> Nucleic Acid Probe <input type="checkbox"/> Point of Care Test <input type="checkbox"/> Other (specify): _____ Date Treatment Administered: ____/____/____ Date of prescription given: ____/____/____	Recommended Treatment: <input type="checkbox"/> Dual therapy with Ceftriaxone 250 mg IM in a single dose PLUS Azithromycin 1 g orally in a single dose or Doxycycline 100 mg orally twice a day for 7 days Alternatives (*Note - Only if Ceftriaxone is not available) <input type="checkbox"/> Dual therapy with Cefixime 400 mg orally PLUS Azithromycin 1g Orally or Doxycycline 100 mg orally twice a day for 7 days If cephalosporin allergic: <input type="checkbox"/> Gemifloxacin 320 mg orally PLUS Azithromycin 2 g orally OR Gentamicin 240 mg IM PLUS Azithromycin 2 g orally
	Date of Specimen Collection: ____/____/____ Name of Testing Laboratory:		

SYPHILIS	NOTE: Call to report [(504) 568-7474], then follow-up with form <input type="checkbox"/> Primary (Genital or oral ulcer) <input type="checkbox"/> Secondary (Rashes) <input type="checkbox"/> Early non-primary non-secondary <input type="checkbox"/> Unknown duration or Late syphilis <input type="checkbox"/> Tertiary –Cardiovascular <input type="checkbox"/> Tertiary- Neurosyphilis <input type="checkbox"/> Congenital <input type="checkbox"/> Other _____	Test(s) Conducted & Results: <input type="checkbox"/> RPR Titer _____ <input type="checkbox"/> VDRL Titer _____ <input type="checkbox"/> MHATP _____ <input type="checkbox"/> FTA _____ <input type="checkbox"/> IgG (EIA) _____ <input type="checkbox"/> TP-PA _____ <input type="checkbox"/> Other _____	Recommended Treatment: <input type="checkbox"/> 2.4 million units Benzathine Penicillin G (BIC) IM X 1 dose Date Administered: ____/____/____ <input type="checkbox"/> 2.4 million units Benzathine Penicillin G (BIC) IM X 3 doses Date 1st Dose Administered: ____/____/____ <input type="checkbox"/> Doxycycline 100 mg orally twice a day for 14 days <input type="checkbox"/> Doxycycline 100 mg orally twice a day for 28 days <input type="checkbox"/> Other: _____ Date prescription given: ____/____/____
	Date of Specimen Collection: ____/____/____ Name of Testing Laboratory:		

OTHER	<input type="checkbox"/> Herpes Simplex Virus (Neonates) <input type="checkbox"/> Other (specify): _____	Test(s) Conducted & Results: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Treatment: <input type="checkbox"/> _____ <input type="checkbox"/> _____
	Date of Specimen Collection: ____/____/____ Name of Testing Laboratory:		

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

Form: STD 43 Revised April 2, 2018 (updates reflect new 2018 CDC syphilis case definitions)

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: STD/HIV Program, 1450 Poydras Street Suite 2136, New Orleans, LA 70112, (504)568-7474. For information about HIV/AIDS Surveillance: <http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/tuber/LouisianaAdministrativeCodeTitle51PublicHealthSanitaryCodeJan2010.pdf>

INSTRUCTIONS FOR COMPLETING STD 43: CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES

Use one (1) form per person to report all applicable STDs. Print legibly.

Provider Information: Write the Name, Addresses, Phone number and Name of Person Reporting in the box or place 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 #, First/Middle Initial/Last Name, Type of Insurance used for visit, Address, City/State/Zip Code, Phone number(s), Date of Birth (DOB), Social Security Number (SSN), in the spaces provided. Check the appropriate box (es) for Sex at Birth, Gender, Pregnancy status, Marital status, Race, Ethnicity, and Gender of Partner(s).

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

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. Write the name of the laboratory where tests were conducted
4. 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:
 - If RPR/VDRL is positive and confirmatory test (e.g., TPPA or IgG-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, IgG-EIA, FTA, etc.)
5. 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 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 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.

MAIL or FAX FORM TO:

LOUISIANA DEPARTMENT OF HEALTH- STD/HIV Program

1450 Poydras Street Suite 2136

Or

PO BOX 60630

New Orleans, LA 70112

NEW ORLEANS LA 70160

FAX to: (504)568-8384

For questions contact the STD/HIV Program at: 504-568-7474 or visit our web site at: <http://www.LAHHUB.org>.