**Boston Public Health Commission**
**Infectious Disease Bureau**
1010 Massachusetts Ave., Boston, MA 02118
*Phone: 617-534-5611 Confidential Fax: 617-534-5905*

**MDPH**
*Fax to (617) 983-6813*

and

**BPHC**
*Fax to (617) 534-5905*

To request **Partner Notification Services** for your patient, please call the Division of STD Prevention at **(617-983-6940)**

# GONORRHEA

*For assistance filling out this form, call (617) 983-6940*

# SUPPLEMENTAL CASE REPORT

Version 8/28/14

## PATIENT INFORMATION

Last Name:_____ First Name:_____ Med Rec #:_____
DOB:___/____/___ Social Security #:_____

Street Address: ☐ Homeless ☐ Incarcerated

City: Zip:

Cell Phone #: Home Phone #:

Primary Language Spoken: ☐ English ☐ Other(specify):_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Unknown

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

Race: (check all that apply)
☐ White ☐ Black ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native
☐ Other(specify):_____ ☐ Unknown

## CLINICAL INFORMATION

Diagnosis Date:_____/_____/_____

Pregnant? ☐ Yes ☐ No ☐ Unknown ☐ Not applicable

Did the case have any symptoms? ☐ Yes ☐ No ☐ Unknown

If symptomatic, what was the patient diagnosed with? (check all that apply):

| Males: | Females: |
|---|---|
| ☐ Urethritis | ☐ Cervicitis |
| ☐ Epididymitis | ☐ PID |
| ☐ Proctitis | ☐ Proctitis |
| ☐ Pharyngitis | ☐ Pharyngitis |
| ☐ DGI | ☐ DGI |
| ☐ Other(specify):_____ | ☐ Other(specify):_____ |

If asymptomatic, why was the patient tested? (check all that apply):

☐ Reported contact to gonococcal case
☐ Screening
☐ Rescreening after previous positive
☐ Patient request
☐ Other(specify):_____

| | | | | |
|---|---|---|---|---|
| Does the patient have sex with: | ☐ Men | ☐ Women | ☐ Both | ☐ Unknown |
| Has the patient exchanged money for sex and/or drugs? | ☐ Yes | | ☐ No | ☐ Unknown |
| Has the patient had sex while intoxicated and/or high? | ☐ Yes | | ☐ No | ☐ Unknown |
| Has the patient travelled out of the state in the last two months? | ☐ Yes (specify):_____ | | ☐ No | ☐ Unknown |
| Has the patient been incarcerated in the last six months? | ☐ Yes | | ☐ No | ☐ Unknown |

Other risk factors:_____

Treatment Date:__ /___/___
☐ Ceftriaxone 250 mg IM AND azithromycin 1 g PO ☐ Ceftriaxone 250 mg IM ☐ Other (specify):_____

## TESTING AGENCY INFORMATION

Provider Name:_____ Facility:_____ Phone #:_____
Address:_____ City:_____ Zip:_____ Fax:_____

Testing Setting:

| | | |
|---|---|---|
| ☐ Drug Treatment Facility | ☐ Private Practice or HMO | ☐ ER or Urgent Care |
| ☐ HIV Counseling, Testing, and Referral Site | ☐ Community Health Center | ☐ School-based Clinic including College/University |
| ☐ Blood Bank | ☐ Hospital-based Clinic | ☐ Military/VA/Job Corps Clinic |
| ☐ Mental Health Services Site | ☐ STD, HIV or Family Planning Clinic | ☐ Correctional Institution |

☐ Other(specify):_____

## TREATING CLINICIAN INFORMATION (If different from testing agency):

☐ Same as testing agency

Clinician Name:_____ Facility:_____ Phone #:_____
Address:_____ City:_____ Zip:_____ Fax:_____

Clinician Practice Setting:

| | | |
|---|---|---|
| ☐ Private Practice or HMO | ☐ STD, HIV, or Family Planning Clinic | ☐ Military/VA/Job Corps Clinic |
| ☐ Community Health Center | ☐ ER or Urgent Care | ☐ Correctional Institution |
| ☐ Hospital-based Clinic | ☐ School-based Clinic including College/University | ☐ Other(specify):_____ |

## ADMINISTRATIVE INFORMATION

Date Form Completed: _____/_____/_____ ☐ Same as treating clinician

Name/Contact Information of person completing report (if not treating clinician):_____