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CHLAMYDIA AND GONORRHEA CASE INVESTIGATION REPORT

To fulfill disease reporting requirements allowed under the Health Insurance Portability and Accountability Act (HIPAA) and required by the Michigan Public Health Act, providers treating residents of Bay County who test positive for chlamydia or gonorrhea must complete and submit this form via fax (989-895-2083) to the Bay County Health Department (BCHD). Thank you for your cooperation and support for BCHD's efforts to help limit the spread of these diseases in Bay County.

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____

Gender:
- ☐ Male
- ☐ Female
- ☐ Non-binary

Race:
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Hawaiian/Pacific Islander
- ☐ Asian
- ☐ Unknown
- ☐ Other (specify) _____

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

Arab Ethnicity:
- ☐ Arab
- ☐ Non-Arab
- ☐ Unknown

RISK FACTOR INFORMATION

Collection of risk factor data informs the development, evaluation, and funding of programs that aim to identify, counsel, and serve at-risk populations.

Method of Case Detection:
- ☐ Screening
- ☐ Self-referred
- ☐ Patient Referred Patient
- ☐ Health Department Referred Partner
- ☐ Cluster Related
- ☐ Other (specify) _____

HIV Status:
- ☐ HIV Positive
- ☐ HIV Negative
- ☐ Equivocal HIV Test
- ☐ Unknown
- ☐ Refused to Answer
- ☐ Did Not Ask

Is the patient pregnant? (women only)	☐ Yes	☐ No	☐ Unknown
In the past 12 months has the patient had sex with a male?	☐ Yes	☐ No	☐ Unknown
In the past 12 months has the patient had sex with a female?	☐ Yes	☐ No	☐ Unknown

LABORATORY INFORMATION

Diagnosis:
- Chlamydia (CT)
- Gonorrhea (GC)

Is the patient aware of the diagnosis?
- ☐ Yes
- ☐ No

If diagnosed with GC, are GC-related sequelae present?
- ☐ Pelvic inflammatory disease (PID)
- ☐ Disseminated gonococcal infection (DGI)
- ☐ None

Patient Name: _____ DOB: ____/____/____

Specimen Collection Date: ____/____/____ Lab Result Date: ____/____/____

Site of Specimen:

- ☐ Blood/Serum
- ☐ Cerebrospinal Fluid (CSF)
- ☐ Cervix/Endocervix
- ☐ Lesion: Extra Genital
- ☐ Lesion: Genital
- ☐ Lymph Node Aspirate
- ☐ Opthalmia/Conjunctiva
- ☐ Rectal/Anal
- ☐ Throat/Oropharynx
- ☐ Urethra
- ☐ Urine
- ☐ Vaginal
- ☐ Other (specify) _____
- ☐ Unknown

Lab Test Type:

- ☐ PCR
- ☐ Nucleic Acid Amplified Target (NAAT)
- ☐ Probe (hybridization method)
- ☐ Culture*
- ☐ Unknown
- ☐ Other (specify) _____

* If culture performed, antimicrobial susceptibility testing results should also be faxed to BCHD.

TREATMENT INFORMATION

Date of Treatment: ____/____/____ If not treated, explain: _____

Specify Drug/Dosage:

Chlamydia

- ☐ Doxycycline (Vibramycin) 100 mg PO BID x 7-10 days
- ☐ Azithromycin 1 g PO x 1 dose
- ☐ Levofloxacin 500 mg PO daily x 7 days

Gonorrhea

- ☐ Ceftriaxone (Rocephin) 500 mg IM (weight < 150 kg)
- ☐ Ceftriaxone (Rocephin) 1g IM (weight ≥ 150 kg)
- ☐ Gentamicin (Garamycin), 240mg IM + Azithromycin 2 g PO x 1 dose
- ☐ Cefixime (Suprax) 800 mg PO
- ☐ Ceftriaxone (Rocephin) 250 mg IM (outdated/incorrect)
- ☐ Azithromycin (Zithromax) 1 g PO x 1 dose (outdated/incorrect)
- ☐ Other or Unspecified Treatment (specify): _____

PARTNER TREATMENT INFORMATION

Partner will be notified by:

- ☐ Patient
- ☐ Health Department
- ☐ Other (specify) _____

Number of partners treated:

_____ Offered and Treated
_____ Offered and Declined Treatment
_____ Expedited Partner Therapy (EPT)
_____ Not Offered Treatment

EDUCATION INFORMATION

Have you informed the patient that…

Retesting is recommended in three months?	☐ Yes	☐ No
Partner(s) must be treated for patient to avoid reinfection?	☐ Yes	☐ No
BCHD will contact patient?	☐ Yes	☐ No
Testing and treatment services are available at BCHD?	☐ Yes	☐ No

TREATING PROVIDER INFORMATION

Provider Name: _____

Phone: _____

Email: _____

Practice Name: _____

Street Address: _____

County: _____