

HIN ID # _____

Return Completed Forms to:
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Telephone: 845-486-3401, Fax: 845-486-3564

Dutchess County Dept of Health Sexually Transmitted Disease Reporting

According to Section 2.1 of the New York Sanitary Code, all of the following information is required to complete an STD Report.

Patient's name: _____ DOB: ____/____/____ Sex: M F
Last First

Address: _____ Phone number: _____
Number and Street

City, Town, Village Zip Code

Race: White Black Native American/Alaskan
 Asian: Other Unknown

Marital Status: Single Married Unknown Other:
Pregnant ? Y _____weeks N Unknown Occupation: _____
Hospitalized? N Y Hospital: _____ Date Admitted: _____ MR#: _____ Employer include telephone: _____

Please circle all that apply

DISEASE: Chlamydia Gonorrhea Syphilis LGV Chancroid Other:

Laboratory Data:

Date of Test: ____/____/____ Laboratory Name: _____

Type of specimen (site)- Blood Cervical Urethral (Penile) Vaginal Pool Throat
 Cord Blood CSF Urine Anal Other:

Results:

Gram Stain Pos Neg Equiv Unk Not Done
Elisa/EIA/IFA: Pos Neg Equiv Unk Not Done
DNA (genprobe) Pos Neg Equiv Unk Not Done
NAAT Pos Neg Equiv Unk Not Done
DFA Pos Neg Equiv Unk Not Done
LCR Pos Neg Equiv Unk Not Done
Culture Pos Neg Equiv Unk Not Done
RPR ~ ART ~ VDRL (circle one) Reactive 1:____ Non Reactive Equiv Unk Not Done
FTA ~ MHA ~ TPPA ~ IGG (circle one) Reactive Non Reactive Equiv Unk Not Done
Other tests: _____

Previous Syphilis Information

Clinical Information:

Prenatal Screening Routine Exam Pap
Check Box Y= Yes, N=No, or UNK= Unknown
Discharge Y N Unk Date of Onset: ____/____/____
Dysuria (Painful urination) Y N Unk Date of Onset: ____/____/____
Abdominal Pain Y N Unk Date of Onset: ____/____/____
Abnormal Bleeding Y N Unk Date of Onset: ____/____/____
Lesion / Rash Y N Unk Date of Onset: ____/____/____
Burning / Itching Y N Unk Date of Onset: ____/____/____
Other symptoms: _____ Date of Onset: ____/____/____

Primary reason(s) for examination: _____

Treatment- Reporting Physician or Facility

Date of Treatment: ____/____/____ Medication(s) and Dosage(s): _____

Physician Name: _____ Telephone: (____) _____

Address: _____ Date of Report: _____