TEXAS DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES (STD)

All providers who diagnose or treat a reportable sexually transmitted disease are required to report to the local health authority within seven (7) days. Complete all spaces or check all boxes as appropriate. Shaded areas are not required by law, but necessary for appropriate identification or follow up.

Patient's Name (Last, First, MI.)	**Date of Birth**	**Age**	**Sex** M ☐ F ☐	**Pregnant?** N ☐ Y ☐ __ _# of weeks
Address (Street, City, State, Zip)		**Hispanic Ethnicity** Yes ☐ No ☐	Race *check all that apply* W ☐ B ☐ AIS ☐ AI ☐ PI ☐	
Telephone:	**Marital Status** S ☐ M ☐ W ☐ D ☐	**Employment**	**Sex of Partners:** F ☐ M ☐ Both ☐	**SSN/Medical record No.**

Provider Type: ☐ Private Physician/Primary Care ☐ Family Planning ☐ Prenatal/OB clinic ☐ Other clinic ☐ Hospital ☐ Emergency ☐ HIV Site ☐ STD Clinic ☐ Drug Treatment ☐ TB clinic ☐ Correctional Facility ☐ Laboratory ☐ Blood/Plasma ☐ Other _____

Exam Date:

Exam Reason: ☐ Volunteer ☐ Referred by Partner ☐ Referred by another provider ☐ DIS Partner Referral ☐ DIS Suspect Referral ☐ Prenatal ☐ Delivery ☐ Screening in Jail/Prison ☐ Other screening

100 Chancroid

Treatment Date: _____
Treatment Given:
☐ Azithromycin
☐ Ceftriaxone
☐ Other: _____

Dosage:
☐ 1 gram
☐ 250 mg IM
☐ Other: _____

☐ No Treatment Given

200 Chlamydia (Not PID)
☐ Urine
☐ Urethral
☐ Vaginal
☐ Cervical
☐ Rectal
☐ Pharyngeal
☐ Ophthalmia

Treatment Date: _____
Treatment Given:
☐ Azithromycin
☐ Doxycycline
☐ Other: _____

Dosage:
☐ 1 gram
☐ 100 mg BID X 7 days
☐ Other: _____

☐ No Treatment Given

300 Gonorrhea (Not PID)
☐ Urine
☐ Urethral
☐ Vaginal
☐ Cervical
☐ Rectal
☐ Pharyngeal
☐ Ophthalmia
☐ Resistant GC

Treatment Date: _____
Treatment Given:
☐ Ceftriaxone
☐ Azithromycin
☐ Other: _____

Dosage:
☐ 250 mg IM
☐ 1 gram
☐ Other: _____

☐ No Treatment Given

490 Pelvic Inflammatory Disease
Disease:
☐ Chlamydial
☐ Gonoccocal
☐ Other or Unknown Etiology

Treatment Date: _____
Treatment Given:
☐ Ceftriaxone
☐ Doxycycline
☐ Other: _____

Dosage:
☐ 250 mg IM
☐ 100 mg BID X 14 days
☐ Other: _____

☐ No Treatment Given

600 Lymphogranuloma Venereum (LGV) ☐

Treatment Date: _____
Treatment Given:
☐ Doxycycline
☐ Other: _____

Dosage:
☐ 100 mg BID X 21 days
☐ Other: _____

☐ No Treatment Given

700 Syphilis
☐ Primary (lesions)*** report within 24 hrs**
☐ Secondary (symptoms) ***report within 24 hrs**
☐ Early Latent (< 1 year)
☐ Late Latent (> 1 year)
☐ Late (with symptoms)
☐ Congenital Syphilis

Y N Unk
☐ ☐ ☐ Neurologic Involvement

Treatment Date: _____
Treatment Given:
☐ Benzathine penicillin G
☐ Doxycycline
☐ Other: _____

Dosage:
☐ 2.4 mu IM X 1
☐ 2.4 mu IM X 3
☐ 100 mg BID X ☐14 days ☐28 days
☐ Other: _____
☐ No Treatment Given

900 HIV/AIDS
☐ Acute HIV *** report within 24 hrs**
☐ HIV Non- AIDS
☐ HIV with AIDS

Reporting HIV on this document serves as proof of timely report; however, the health department requires additional information on HIV patients.

Reporting Address:

(Local Health Authority place mailing information here)

Reported By:

_____

Name Office Address City Phone Number

STD-27 (Rev 5/2020)

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Use the spaces below to report your patient's sexual or needle sharing partner(s) for confidential notification by a Disease Intervention Specialist (DIS). When those listed below are notified of exposure, the DIS will not reveal your patient's identity.

Please consult me or my designated staff before contacting my patient: ☐

Designated Staff Person:	**Telephone:**	**Extension:**	**Best time to call me or my staff:**

Partner's Name (Last, First, MI.)	Nickname or alias:	Hispanic Ethnicity Yes ☐ No ☐	Race	Sex	DOB or approximate age

Partner's Address (Street, Apartment, City, State)	Telephone: Home: ________ Work: ________	Best time to call or visit partner:

Date of last exposure to patient: ____________________

Partner's Marital Status: S ☐ M ☐ W ☐ D ☐

Partner's Place of Employment: ____________________

Work Hours: ____________________

Treatment given: ____________________

Date: ____________________

Partner's Name (Last, First, MI.)	Nickname or alias:	Hispanic Ethnicity Yes ☐ No ☐	Race	Sex	DOB or approximate age

Partner's Address (Street, Apartment, City, State)	Telephone: Home: ________ Work: ________	Best time to call or visit partner:

Date of last exposure to patient: ____________________

Partner's Marital Status: S ☐ M ☐ W ☐ D ☐

Partner's Place of Employment: ____________________

Work Hours: ____________________

Treatment given: ____________________

Date: ____________________

Partner's Name (Last, First, MI.)	Nickname or alias:	Hispanic Ethnicity Yes ☐ No ☐	Race	Sex	DOB or approximate age

Partner's Address (Street, Apartment, City, State)	Telephone: Home: ________ Work: ________	Best time to call or visit partner:

Date of last exposure to patient: ____________________

Partner's Marital Status: S ☐ M ☐ W ☐ D ☐

Partner's Place of Employment: ____________________

Work Hours: ____________________

Treatment given: ____________________

Date: ____________________

Mail or fax to local health department or DSHS HIV/STD Control Program.
Go to dshs.texas.gov/hivstd/reporting/ for the address of your local/regional health authority or call (737) 255-4300.

◆ ◆ ◆ **DO NOT EMAIL THIS FORM** ◆ ◆ ◆

TEXAS Health and Human Services

Texas Department of State Health Services