

All providers who diagnose or treat a reportable sexually transmitted infection 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.

STD-27 (Rev 11/2021)

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED INFECTIONS (STI)**

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:			
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 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.

