



33388

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ILLINOIS CONFIDENTIAL MORBIDITY REPORT OF SEXUALLY TRANSMITTED INFECTIONS**

PATIENT INFORMATION

FIRST NAME

M.I.

Expedited Partner Therapy (EPT) given to patient with **CHLAMYDIA** and/or **GONORRHEA** for partner(s).

Yes No Unknown

If yes, for how many partners?

LAST NAME

IDOC #

STREET ADDRESS

APARTMENT NUMBER

CITY

STATE

ZIP CODE

COUNTY OF RESIDENCE

PHONE NUMBER

DATE OF BIRTH

RACE (Select All That Apply)

ETHNICITY

SEX AT BIRTH

CURRENT GENDER

SEX OF SEX PARTNER(S) (Select All that Apply)

PREGNANT Yes No

EST. DUE DATE

DIAGNOSIS**Chlamydia****Gonorrhea****Other STIs****Syphilis Stage****Syphilis Symptoms**

Genito-urinary Rectal
 Ophthalmia PID*
 Pneumonia LGV*
 Other: _____

Genito-urinary Rectal
 Ophthalmia DGI*
 Pharyngeal PID*
 Other: _____

Chancroid
DATE OF TEST/EXAM
 / /

Primary
 Secondary
 Early, NPNS*
 Late or Unknown
 Congenital

Lesion/Chancre None
 Rash (P/P* or GBR*)
 Neurologic: _____
 Ocular: _____
 Otic: _____
 Other: _____

LABORATORY TEST(S) RELATED TO DIAGNOSIS**Chlamydia Test****Gonorrhea Test****Syphilis Tests**

DATE POSITIVE TEST COLLECTED

DATE POSITIVE TEST COLLECTED

Serologic Screening Test: RPR, VDRL

DATE OF TEST / / RESULT
 Pos
 Neg

Titer 1: **TREATMENT (RX) INFORMATION (See reverse side for treatment codes)**

Date(s) Treated

RX Codes

Other

Serologic Confirmatory Test: FTA-ABS, TP-PA, EIA

DATE OF TEST / / RESULT
 Pos
 Neg

Darkfield / DFA-TP or PCR (from lesion)

DATE OF TEST / / RESULT
 Pos
 Neg

CSF-VDRL

DATE OF TEST / / RESULT
 Pos
 Neg

Syphilis Neurologic Involvement Verified (Positive CSF-VDRL) Possible

FACILITY WHERE SPECIMEN WAS COLLECTED

Name _____

Address _____

City _____ Phone _____

FACILITY WHERE PATIENT WAS TREATED

Name _____

Address _____

City _____ Phone _____

Name of Person Completing Form _____

If you need assistance in sex partner referral, need additional forms, etc., call your local health department STI program.

Submit this report to your local health department:

If NO local health department, contact:

Illinois Department of Public Health
ATTN: STI Section
525 W. Jefferson St., Ground Floor
Springfield, IL 62761
Phone: 217-782-2747

Updated 2022



Use the Rx codes below for completing the treatment information on the reverse side.

Rx Code	CHLAMYDIA
210	AZITHROMYCIN 1 GM
215	DOXYCYCLINE 100 MG BID X 7 DAYS
220	DOXYCYCLINE 100 MG BID X 14 DAYS
225	DOXYCYCLINE 100 MG BID X 10 DAYS
205	AMOXICILLIN 500 MG TID X 7 DAYS
245	ERYTHROMYCIN BASE 250 MG QID X 14 DAYS
255	ERYTHROMYCIN BASE 500 MG QID X 7 DAYS
265	OFLOXACIN 300 MG BID X 7 DAYS
285	LEVOFLOXACIN 500 MG DAILY X 7 DAYS
256	PEDIATRIC TREATMENT (Please indicate drug, dose, and regimen under "Other")
600	IV THERAPY (Please indicate drug, dose, and regimen under "Other")

Note: If dual therapy was administered, enter the appropriate Rx Code listed under Gonorrhea.

Rx Code	GONORRHEA (DUAL THERAPY ¹)
325	CEFTRIAXONE 500 MG
330	CEFIXIME 800 MG
125	GEMIFLOXACIN 320 MG PLUS AZITHROMYCIN 2 GM
130	GENTAMICIN 240 MG PLUS AZITHROMYCIN 2 GM
120	CEFTRIAXONE 500 MG PLUS DOXYCYCLINE 100 MG BID X 7 DAYS ²
105	CEFIXIME 800 MG PLUS DOXYCYCLINE 100 MG BID X 7 DAYS ²
357	PEDIATRIC TREATMENT (Please indicate drug, dose, and regimen under "Other")
600	IV THERAPY (Please indicate drug, dose, and regimen under "Other")

Rx Code	SYPHILIS	Rx Code	SYPHILIS
705	BENZATHINE PENICILLIN G 2.4 MU	770	AQ. CRYST. PCN IV X 10-14 DAYS
725	BENZATHINE PENICILLIN G 2.4 MU X 3 WEEKS	775	DOXYCYCLINE 100 MG BID X 14 DAYS
755	BENZATHINE PENICILLIN G PEDIATRIC	780	DOXYCYCLINE 100 MG BID X 28 DAYS
765	PROCAINE PENICILLIN G IM X 10-14 DAYS		

Rx Code	CHANCROID	Rx Code	LYMPHOGRANULOMA VENEREUM (LGV)
400	AZITHROMYCIN 1 GM	500	DOXYCYCLINE 100 MG BID X 21 DAYS
405	CEFTRIAXONE 250 MG	505	ERYTHROMYCIN BASE 500 MG QID X 21 DAYS
410	CIPROFLOXACIN 500 MG BID X 3 DAYS	510	AZITHROMYCIN 1 GM WEEKLY X 3 WEEKS
415	ERYTHROMYCIN BASE 500 MG TID X 7 DAYS		

Rx Code	MISCELLANEOUS CODES
000	NO TREATMENT (Applies to All Diagnoses)
800	OTHER ADEQUATE TREATMENT (Please indicate drug, dose, and regimen under "Other")

¹ Administration of two medications.

² If chlamydial infection has not been excluded, treat for chlamydia with doxycycline 100 mg orally 2 times/day for 7 days.

*Abbreviations:

MTF-Male to Female **FTM**-Female to Male **PID**-Pelvic Inflammatory Disease **DGI**-Disseminated Gonococcal Infection
LGV-Lymphogranuloma venereum **NPNS**-non-primary, non-secondary **P/P**-Plantar/Palmar **GBR**-Generalized Body Rash

For more details on the CDC STD Treatment Guidelines or information on STDs, visit: www.cdc.gov/std.

The [Illinois Department of Public Health](http://www.idph.state.il.us) is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Illinois Sexually Transmissible Disease Control Act ([410 ILCS 325](http://www.ilcs.com), ch. 111 ½, par. 7401 et seq). Disclosure of this information is MANDATORY.