Boston Public Health Commission
Infectious Disease Bureau
1010 Massachusetts Ave., Boston, MA 02118
Phone: 617-534-5611 Confidential Fax: 617-534-5905

MDPH
Fax to (617) 887-8789 and

BPHC
Fax to (617) 534-5905

To request **Partner Notification Services** for your patient, please call the Division of STD Prevention at **(617-983-6940)**

GONORRHEA

For assistance filling out this form, call (617) 983-6940

SUPPLEMENTAL CASE REPORT

Version 8/28/14

PATIENT INFORMATION

Last Name:_____ First Name:_____ Med Rec #:_____
DOB:___/____/___ Social Security #:_____

Street Address: ☐ Homeless ☐ Incarcerated

City: Zip:

Cell Phone #: Home Phone #:

Primary Language Spoken: ☐ English ☐ Other(specify):_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Unknown

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

Race: (check all that apply)
☐ White ☐ Black ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native
☐ Other(specify):_____ ☐ Unknown

CLINICAL INFORMATION

Diagnosis Date:_____/_____/_____

Pregnant? ☐ Yes ☐ No ☐ Unknown ☐ Not applicable

Did the case have any symptoms? ☐ Yes ☐ No ☐ Unknown

If symptomatic, what was the patient diagnosed with? (check all that apply):

Males:	Females:
☐ Urethritis	☐ Cervicitis
☐ Epididymitis	☐ PID
☐ Proctitis	☐ Proctitis
☐ Pharyngitis	☐ Pharyngitis
☐ DGI	☐ DGI
☐ Other(specify):_____	☐ Other(specify):_____

If asymptomatic, why was the patient tested? (check all that apply):

☐ Reported contact to gonococcal case
☐ Screening
☐ Rescreening after previous positive
☐ Patient request
☐ Other(specify):_____

Does the patient have sex with:	☐ Men	☐ Women	☐ Both	☐ Unknown
Has the patient exchanged money for sex and/or drugs?	☐ Yes		☐ No	☐ Unknown
Has the patient had sex while intoxicated and/or high?	☐ Yes		☐ No	☐ Unknown
Has the patient travelled out of the state in the last two months?	☐ Yes (specify):_____		☐ No	☐ Unknown
Has the patient been incarcerated in the last six months?	☐ Yes		☐ No	☐ Unknown

Other risk factors:_____

Treatment Date:__ /___/___
☐ Ceftriaxone 250 mg IM AND azithromycin 1 g PO ☐ Ceftriaxone 250 mg IM ☐ Other (specify):_____

TESTING AGENCY INFORMATION

Provider Name:_____ Facility:_____ Phone #:_____
Address:_____ City:_____ Zip:_____ Fax:_____

Testing Setting:

☐ Drug Treatment Facility	☐ Private Practice or HMO	☐ ER or Urgent Care
☐ HIV Counseling, Testing, and Referral Site	☐ Community Health Center	☐ School-based Clinic including College/University
☐ Blood Bank	☐ Hospital-based Clinic	☐ Military/VA/Job Corps Clinic
☐ Mental Health Services Site	☐ STD, HIV or Family Planning Clinic	☐ Correctional Institution

☐ Other(specify):_____

TREATING CLINICIAN INFORMATION (If different from testing agency):

☐ Same as testing agency

Clinician Name:_____ Facility:_____ Phone #:_____
Address:_____ City:_____ Zip:_____ Fax:_____

Clinician Practice Setting:

☐ Private Practice or HMO	☐ STD, HIV, or Family Planning Clinic	☐ Military/VA/Job Corps Clinic
☐ Community Health Center	☐ ER or Urgent Care	☐ Correctional Institution
☐ Hospital-based Clinic	☐ School-based Clinic including College/University	☐ Other(specify):_____

ADMINISTRATIVE INFORMATION

Date Form Completed: _____/_____/_____ ☐ Same as treating clinician

Name/Contact Information of person completing report (if not treating clinician):_____