Massachusetts Department of Public Health
Bureau of Infectious Disease and Laboratory Sciences
Office of Integrated Surveillance and Informatics Services
305 South Street, Jamaica Plain, MA 02130
Phone: 617-983-6801 Confidential Fax: 617-983-6813

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

☐ CHANCROID ☐ LYMPHOGRANULOMA VENEREUM (LGV)
☐ GRANULOMA INGUINALE ☐ PID (AGENT UNKNOWN)

CASE REPORT FORM

Version 5/16/2018
For assistance filling out this form, call (617) 983-6801.
If you need help with this case, please call (617) 983-6940.

PATIENT INFORMATION

Last Name:_____ First Name:_____ DOB:___/____/____ Med Rec #:_____
Middle Initial: _____ 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:_____/_____/_____

Did the patient have any symptoms? ☐ Yes ☐ No ☐ Unknown
If yes, what was the patient diagnosed with? _____

Pregnant: ☐ Yes ☐ No ☐ Unknown ☐ Not applicable

If asymptomatic, why was the patient tested? Check all that apply.
☐ Contact to STD ☐ Patient request ☐ Other _____

Lab test, if performed (e.g. biopsy, culture, serology):	Specimen site:	Result:
1. _____ →	1. _____ →	1. _____
2. _____ →	2. _____ →	2. _____
3. _____ →	3. _____ →	3. _____

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 year?	☐ Yes (specify):_____		☐ No	☐ Unknown
Has the patient been incarcerated in the last 60 days?	☐ Yes		☐ No	☐ Unknown

Other risk factors:_____

Treatment Start Date:__ /___/___ Treatment: _____

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):_____