Massachusetts Department of Public Health
Bureau of Infectious Disease and Laboratory Sciences
305 South Street, Jamaica Plain, MA 02130
Phone: 617-983-6801 Confidential Fax: 617-983-6813
https://www.mass.gov/lists/infectious-disease-case-report-forms

Please call the confidential Partner Services and Reporting Line for assistance at 617-983-6999

GONORRHEA

SUPPLEMENTAL CASE REPORT

Version 8/2022

PATIENT INFORMATION

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

Sex assigned at birth: ☐ Male ☐ Female ☐ Intersex ☐ Unknown

Sexual orientation:
- ☐ Bisexual and/or Pansexual
- ☐ Lesbian, gay, or homosexual
- ☐ Straight or heterosexual
- ☐ Something else/Other not listed above (e.g. queer, asexual)
- ☐ Don't know

Current gender: ☐ Female ☐ Male
- ☐ Nonbinary, genderqueer or not exclusively Male or Female
- ☐ Questioning/not sure of my gender identity
- ☐ Unsure what this question is asking
- ☐ Prefer not to answer
- ☐ Unknown

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

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

Street Address:

City: Zip:

Cell Phone #: Home Phone #:

Housing Status: ☐ Experiencing homelessness ☐ Incarcerated

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

CLINICAL INFORMATION

Diagnosis Date:_____/_____/_____

Pregnant? ☐ Yes ☐ No ☐ Unknown ☐ Not applicable

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

If <u>symptomatic</u>, what was the patient diagnosed with? (check all that apply):
- ☐ Cervicitis ☐ PID ☐ Epididymitis
- ☐ Urethritis ☐ Proctitis ☐ Pharyngitis
- ☐ Discharge (specify site):_____
- ☐ Disseminated Gonococcal Infection
- ☐ Other(specify):_____

If <u>asymptomatic</u>, why was the patient tested? (check all that apply):
- ☐ Reported contact to gonococcal case
- ☐ Screening
- ☐ Rescreening after previous positive
- ☐ Patient request
- ☐ Other(specify):_____

Specimens Collected (check all that apply):
- ☐ Urogenital
- ☐ Rectal
- ☐ Oropharyngeal
- ☐ Eye
- ☐ Other(specify):_____

Did patient receive comprehensive STI and HIV testing:
- Syphilis: ☐ Yes ☐ No ☐ Unknown
- Chlamydia: ☐ Yes ☐ No ☐ Unknown
- HIV: ☐ Yes ☐ No ☐ Unknown

Treatment Date:__ /___/___
☐ Ceftriaxone 500 mg IM ☐ Other (specify):_____

TESTING AGENCY INFORMATION

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

TREATING CLINICIAN INFORMATION (if different from testing agency):

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

ADMINISTRATIVE INFORMATION

Date Form Completed: _____/_____/_____ ☐ Same as treating clinician
Name/Contact Information of person completing report (if not treating clinician):_____