

KANSAS SEXUALLY TRANSMITTED INFECTION CASE REPORT FORM

In accordance with K.S.A. 65-118, 65-128, 65-6001 - 65-6007, K.A.R. 28-1-2, 28-1-4, and 28-1-18.

Today's Date:		Patient's DOB:	
Patient's Name:			
	(Last)	(First)	(Middle)
Home Phone:		Work Phone:	Cell Phone:
Residential Address:			
City:		State:	Zip Code:
Ethnicity:		Race:	
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender
Pregnancy Status: <small>(Females Only)</small>		HIV Status:	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown/Did Not Ask	
		Gender of Sex Partners: <small>(check all that apply)</small>	
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown/Did Not Ask	
Infection Being Reported: <small>(check all that apply)</small>		Physician Name:	
<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis			
		Physician Phone:	
		Name of Person Reporting:	
		Phone of Person Reporting:	
Laboratory Information			
Name of Laboratory:		Name of Test Performed:	
Specimen Collection Date:	Results of Test:	Date Reported to You:	
TREATMENT INFORMATION			
Date of Treatment:			
Treatment Type and Dosage:			
<input type="checkbox"/> Ceftriaxone 500mg ²		<input type="checkbox"/> Azithromycin 1g	
<input type="checkbox"/> Benzathine Pencillin G L.A. 2.4 mu		<input type="checkbox"/> Benzathine Pencillin G L.A. 2.4mu X 3	
<input type="checkbox"/> Other: Please specify drug & dosage:			

Please fax reports to the Kansas Department of Health & Environment, STI/HIV Section at:
 Fax: 785-559-4225 Phone: 785-296-6174