

Oklahoma State Department of Health  
**Confidential Morbidity Report of Sexually Transmitted Diseases**

*(Please complete this form as accurately and legibly as possible.)*

**A. Demographic Information**

Patient Last Name:                      First:                      Middle:			Date of Birth: / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (Specify) : _____
Other Names Previously Used by Patient <i>(i.e. Married or Maiden Name):</i>			Race –(Check All that Apply):	
Patient's Home Address <i>(House/Apt No. and Street):</i>			<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Unknown <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Other (Specify): _____	
Patient Phone:		City:	State:	Zip Code:
County:		** Free electronic reporting is now available. See reverse side of form for more information about the PHIDDO reporting system.		
			Hispanic Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**B. Diagnosis**

**C. Prior History**

<b>Chlamydia</b> <input type="checkbox"/> Genito-Urinary <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Rectal <input type="checkbox"/> PID <input type="checkbox"/> Other (Specify): _____ _____	<b>Gonorrhea</b> <input type="checkbox"/> Genito-Urinary <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Rectal <input type="checkbox"/> PID <input type="checkbox"/> Other (Specify): _____ _____	<b>Syphilis</b> <input type="checkbox"/> Primary (Chancre) <input type="checkbox"/> Secondary (Symptoms) <input type="checkbox"/> Early Latent <input type="checkbox"/> Latent <input type="checkbox"/> Congenital (Specify manifestations): _____ _____	<input type="checkbox"/> Pregnant (at time of test)  <input type="checkbox"/> PID (presumptive)  <input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Syphilis Tx History Approx. Date: Facility/Location:  <input type="checkbox"/> HIV/AIDS Tx History Approx. Date: Facility/Location:
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**D. Positive Laboratory Tests Related To Diagnosis**

**E. Treatment Information**

Specimen Collection Date	Laboratory Name	Type of Test	Result	Tx Date	Medication <input type="checkbox"/> Not Treated

**F. Provider/Facility Information/Clinic Type**

Facility Name:		Clinic Type: <input type="checkbox"/> STD <input type="checkbox"/> Family Planning <input type="checkbox"/> Maternity <input type="checkbox"/> Other (Specify): _____	
Physician Name:			
Address:			
City, State & Zip:		Phone: (       )	
Form Completed by:		Date Form Submitted:	

**For instructions, please refer to the reverse side of this form.** For further information or assistance, contact:

Oklahoma State Department of Health  
 1000 NE 10<sup>th</sup> St, Mail Drop 0308, Oklahoma City, OK 73117  
 Phone: (405) 271-4636, Fax: (405) 271-1187

**Need Supply of:**  
 Forms     Envelopes

Oklahoma State Department of Health  
**Confidential Morbidity Report of Sexually Transmitted Diseases**  
**ODH Form 228 GUIDELINES** (Revised 10/09)

This form is intended for use by all health care providers diagnosing and/or treating sexually transmitted diseases in the state of Oklahoma. Report only those sexually transmitted diseases indicated on this form: gonorrhea, chlamydia, syphilis, HIV/AIDS, and/or presumptive Pelvic Inflammatory Disease (PID). All diagnoses, laboratory tests and treatment information for a patient with multiple infections may be reported on a single form.

The provider (or designee) is responsible for mailing all original forms to the HIV/STD Service of the Oklahoma State Department of Health in the confidential, pre-addressed, postage-paid gray envelopes. **Public Health Code (OAC § 310:515-1-3, OAC § 310:515-1-4) requires reporting of HIV/AIDS and syphilis within 24 hours, and chlamydia, gonorrhea, and PID within 30 days of diagnosis.**

Form Sections:

**A. Demographic Information**

Complete all entries in full. **If patient is under 14 years of age, and abuse or assault is suspected, notify the Department of Human Services (DHS), as required by Oklahoma law (21 OS § 1112, 21 OS § 1113, 21 OS § 1114, Schedule S-2).**

**B. Diagnosis**

1. **Pregnant:** Indicate with an "X" if client is pregnant at the time of testing.
2. **Presumptive PID:** This section is to be completed when laboratory confirmation was not made or is inconclusive. Indicate with an "X", if client has been treated for PID, but gonorrhea/chlamydia testing was negative, and indicate date of specimen collection.
3. **HIV/AIDS:** Indicate a positive test result with an "X".
4. **Gonorrhea:** Indicate with an "X" all appropriate sites of infection. "Other" refers to disseminated disease. Please stipulate.
5. **Chlamydia:** Indicate with an "X" all appropriate sites of infection. "Other" refers to disseminated disease. Please stipulate.
6. **Syphilis:** Indicate with an "X" the current staging of disease.

**C. Prior History**

1. **Syphilis Tx History:** Indicate with an "X" if patient has prior history of syphilis treatment. Please indicate the approximate date of treatment, and name and location of treating facility if available.
2. **HIV/AIDS Tx History:** Indicate with an "X" if patient has prior history of HIV/AIDS treatment. Please indicate the approximate date of treatment, and name and location of treating facility if available.

**D. Laboratory Tests Related To Diagnosis**

1. **Date of Specimen Collection:** Indicate date of specimen collection.
2. **Lab Name:** Indicate laboratory name where specimen was sent for testing.
3. **Type of Test:** Indicate the type of test performed. (Example: DNA probe or culture, wet prep, urine, dark field, smear, RPR/VDRL, FTA/TPPA, Western Blot, EIA, etc.)
4. **Results:** Indicate positive test results only. Specify titer for syphilis if available. For presumptive diagnoses, a negative test result should be marked.

**E. Treatment Information**

Indicate date of treatment, name(s) of medication, dosage and route. If client was not treated, indicate this with an "X" in the appropriate box.

**F. Provider/Facility/Clinic Type Information**

Print, type, or stamp all entries. If Health Department, check appropriate **Clinic Type**. If applicable, indicate department name (Example: Emergency Room, Pediatric Clinic, Women's Health, etc.) Indicate with "X" in the appropriate box(es) if more forms and/or envelopes are needed.

**\*\*PHIDDO (Public Health Investigation and Disease Detection of Oklahoma)**

The preferred method of reporting diseases or conditions to the OSDH is through the secure, web-based PHIDDO system. PHIDDO is a user-friendly, internet-based application which is only accessible to persons with specific authorization to enter and view records and information. Online case reporting eliminates the need for faxing and mailing reports to OSDH.

If you are a Physician, Physician Assistant, Nurse Practitioner, Infection Preventionist, Laboratorian, or any other clinical or healthcare professional who would be submitting cases of reportable diseases PHIDDO will be a good reporting option. To register or if you have any questions about PHIDDO, please contact Tony McCord or Anthony Lee at (405) 271-4060.