Oklahoma State Department of Health

Confidential Morbidity Report of Sexually Transmitted Diseases

Find this and other reporting forms at hivstd.health.ok.gov

A. Patient Information

Patient Name			Current Gender	Sex at Birth
Last:	**First:**	**Middle:**	☐Male ☐Female ☐Other *(specify):*	☐Male ☐Female

Other Names Used *(i.e. Married or Maiden Name)*:	**Date of Birth:** / /	Gender of Sexual Partners ☐Male ☐Female ☐Both ☐Unknown

Home Address *(House/Apt # and Street)*: ☐Homeless ☐Incarcerated			**Race** *(Check all that apply)* ☐White ☐Asian ☐Black/African American ☐American Indian/Alaska Native ☐Pacific Islander/Native Hawaiian ☐Unknown ☐Other *(specify):*
City:	**State:**	**Zip Code:**	
County:	**Phone:** ☐Home ☐Cell ☐Work		**Hispanic Ethnicity** ☐Yes ☐No ☐Unknown

B. Diagnosis & Treatment Information

Diagnosis	Prior Syphilis History	Specimen Type	Test Type
☐**CHLAMYDIA** ☐**GONORRHEA** **SYPHILIS:** ☐Primary ☐Secondary ☐Early Latent ☐Latent ☐Unknown Stage	**Does patient have <u>prior</u> history of syphilis?** ☐Yes ☐No ☐Unknown Test Date: Treatment Date: Facility:	☐Cervical ☐Pharyngeal ☐Rectal ☐Serum ☐Urine ☐Urethral ☐Vaginal ☐Other(*specify):*	☐CT Culture ☐CT DNA ☐GC DNA ☐GC Culture ☐EIA ☐FTA ☐RPR ☐TPPA ☐Other *(specify):*

Expedited Partner Therapy	Complications/Symptoms	Pregnancy
☐Yes; *# issued=* ☐1 ☐2 ☐3 ☐No; *specify reason=*_____ _____ ☐Unknown	☐Congenital Infection* ☐Rash ☐Chancre/lesion ☐Pelvic Inflammatory Disease (PID) ☐Other Syphilis Symptoms *(specify):*	**Is patient <u>currently</u> pregnant?** ☐No ☐Yes ☐Unknown Number of Weeks:

Laboratory Name	Specimen Collection Date	Result

Medication ☐NKA ☐Allergies (please list: _____)	Dosage	Treatment Date
☐ Azithromycin (Zithromax)	☐ 1g ☐ 2g ☐ 2g plus 240mg Gentamicin	
☐ Ceftriaxone (Rocephin) IM	☐ 250mg ☐ mg	
☐ Doxycycline 100mg PO BID	☐ 7 days ☐ 10 days ☐ 14 days	
☐ Benzathine Penicillin G 2.4 mu IM	☐ 1 dose ☐ 3 doses	
☐ Not Treated ☐ Other *(specify):*		

C. Provider/Facility Information

Form Completed by:		**Physician Name:**	
Facility Name:		**Clinic Type:** ☐Family Planning ☐Women's Health ☐Family Medicine ☐STD ☐Other *(specify):*	
Address:			**Phone:** ( )
City:	**State:**	**Zip:**	**Date Form Completed:**

Oklahoma State Department of Health

1000 N.E. 10th Street, Mail Drop 0308, Oklahoma City, OK 73117
Phone: (405) 271-4636 | Fax: (405) 271-1187
****See reverse side for instructions on completing this form and for information on *FREE ELECTRONIC REPORTING*****

Need Supply of:
☐Forms
☐Envelopes

Oklahoma State Department of Health
Confidential Morbidity Report of Sexually Transmitted Diseases
ODH Form 228 GUIDELINES (Revised 1/2016)

This form is intended for use by all health care providers diagnosing and/or treating sexually transmitted diseases in the state of Oklahoma. **Public Health Codes (OAC § 310:515-1-3 and OAC § 310:515-1-4) require reporting of HIV/AIDS and syphilis within 24 hours, and chlamydia and gonorrhea within 30 days of diagnosis.**
All STD diagnoses, laboratory tests, and treatment information for a patient with multiple STD infections may be reported on a single form. Report only gonorrhea, chlamydia, or syphilis on this form. The following diseases should be reported to OSDH separately:

- **Hepatitis B or Hepatitis C**: Please report cases of Hepatitis B or C on ODH Form 295 (available at *hivstd.health.ok.gov*) or report electronically, using PHIDDO.
- **HIV/AIDS:** Please report cases of adult HIV/AIDS on CDC Form 50.42a and pediatric HIV/AIDS on CDC Form 50.042b (available at *hivstd.health.ok.gov*) or report electronically, using PHIDDO.

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. All sections of this form must be completed.
Form Sections:

A. Patient 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 & Treatment Information

1. **Diagnosis**
   a. **Chlamydia:** Check the appropriate box if diagnosing the patient with chlamydia and check the appropriate box(es) or list any complications present. Complete the prior syphilis history section.
   b. **Gonorrhea:** Check the appropriate box if diagnosing the patient with gonorrhea and check the appropriate box(es) or list any complications present. Complete the prior syphilis history section.
   c. **Syphilis:** Check the appropriate box if diagnosing the patient with syphilis. Check the appropriate box for the stage of syphilis (primary, secondary, etc.). Complete the prior syphilis history section. If prior history exists, give the approximate date of prior test and treatment, and the name and location of prior test and treatment, if available. Check the appropriate box(es) or list any complications present.
2. **Prior Syphilis History:** Complete the prior syphilis section for any diagnosis.
3. **Specimen Type**: Check the appropriate box(es) for the type of specimen collected.
4. **Test Type**: Check the appropriate box(es) for the type of test performed on the specimen.
5. **Expedited Partner Therapy:** Providing treatment or Rx for the sex partners to the persons with sexually transmitted diseases (STD) without an intervening medical evaluation of the partner(s). Check the appropriate box(es).
6. **Complications and Symptoms:** Check the appropriate box(es) or list any complications or symptoms present with any diagnosis.
7. **Pregnancy**: Check the appropriate box for the patient's current pregnancy status. If the patient is currently pregnant, specify the number of weeks of gestation at the time of specimen collection.
8. **Laboratory Name**: Indicate the laboratory name(s) where each specimen was sent for testing.
9. **Specimen Collection Date**: Indicate the date the specimen was collected.
10. **Result**: Indicate positive, reactive, negative, non-reactive, and specify quantity or titer when applicable.
11. **Medication**: Check the appropriate box(es), or specify the type of medication given to the patient. If the patient was not treated, check the appropriate box.
12. **Dosage**: Check the appropriate box, or specify the dosage of medication given to the patient.
13. **Treatment Date**: Indicate the date(s) the patient was treated. Please contact (405) 271-4636 with any questions about treatment recommendations.

C. Provider/Facility Information

Print, type, or stamp all entries. If your facility is a health department, check the appropriate clinic type. If applicable, indicate department name (emergency room, pediatric clinic, women's health, etc.). Check the appropriate box(es) if more forms and/or envelopes are needed.

*__Congenital Infections__ of chlamydia, gonorrhea or syphilis are conditions present at birth due to maternal infections. Congenital syphilis is a severe, disabling, and often life-threatening syphilis infection seen in infants.

Electronic Reporting: PHIDDO (Public Health Investigation and Disease Detection of Oklahoma)
PHIDDO is a secure, user-friendly, web-based reporting option for any clinical or healthcare professional required to submit cases of reportable diseases to OSDH. Because PHIDDO eliminates the need for faxing and mailing reports, it is our preferred method of reporting. PHIDDO is provided at no cost to your facility. To register or get more information, please contact: **Tony McCord or Anthony Lee at (405) 271-4060.**