

For provider use only:

PATIENT NAME _____ DATE OF SPECIMEN COLLECTION _____

PATIENT DATE OF BIRTH _____

DIAGNOSIS _____

NAME OF DIAGNOSING PHYSICIAN _____

NAME OF DIAGNOSING FACILITY/CLINIC _____

TREATMENT (include drug, dosage, duration) _____

DATE OF TREATMENT _____

PREGNANCY STATUS _____

COMPLICATIONS (i.e., pelvic inflammatory disease, etc.) _____

PLEASE READ VERY CAREFULLY!

You are being treated for a sexually transmitted disease (STD). An important part of your health care is treatment of your sex partners. Sex partners of persons infected with an STD may not know they are infected or may only notice a mild infection. It is very important that ALL of your current sex partners are treated in order to prevent you from becoming re-infected. Your name is **strictly confidential** and will not be used if the Department of Health refers partners to the clinic for medication.

If you have questions about STDs, please contact your health-care provider, local public health department or the North Dakota Department of Health toll free at 1-800-472-2180.

Please list ALL persons with whom you are currently having sex. Provide as much information as you can.

If we need to contact you, where are you currently living?

Phone # _____ Cell Phone # _____

Address _____ City _____

E-mail address _____

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PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT EACH OF YOUR CURRENT PARTNERS

1. Name: _____ Gender _____ Race _____
Age _____ Date of Birth _____ If partner is female, is she pregnant? Yes/No
Address _____ Phone _____ Cell _____
E-mail address _____

Name and relation (i.e. John Smith, dad) of person your partner lives with?

DESCRIBE WHERE your partner lives: _____

Name/Phone of place where your partner goes to work/school _____

WHEN is the LAST time you had sex with this person? _____

Please check one of the following:

- My current partner is with me and is being treated now.
- I will bring my current partner with me to the clinic to be treated.
- I will contact my partner(s) directly and refer him/her to the clinic.

Anything else you can think of to help locate, identify and contact this partner (nickname, piercings, tattoos, car)? _____

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TREATMENT OF PARTNER (include drug, dosage, duration) _____

TREATMENT OF PARTNER BY EPT (CIRCLE YES or NO)

DATE OF TREATMENT/DISPENSED _____

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2. Name: _____ Gender _____ Race _____
Age _____ Date of Birth _____ If partner is female, is she pregnant? Yes/No
Address _____ Phone _____ Cell _____
E-mail address _____

Name and relation (i.e. John Smith, dad) of person your partner lives with?

DESCRIBE WHERE your partner lives: _____

Name/Phone of place where your partner goes to work/school _____

WHEN is the LAST time you had sex with this person? _____

Please check one of the following:

- My current partner is with me and is being treated now.
- I will bring my current partner with me to the clinic to be treated.
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TREATMENT OF PARTNER BY EPT (CIRCLE YES or NO)

DATE OF TREATMENT/DISPENSED _____

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3. Name: _____ Gender _____ Race _____
Age _____ Date of Birth _____ If partner is female, is she pregnant? Yes/No
Address _____ Phone _____ Cell _____
E-mail address _____

Name and relation (i.e. John Smith, dad) of person your partner lives with?

DESCRIBE WHERE your partner lives: _____

Name/Phone of place where your partner goes to work/school _____

WHEN is the LAST time you had sex with this person? _____

Please check one of the following:

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