Fax Report to the STD Confidential Fax Line: (609) 826-4870

The State of New Jersey Department of Health

Sexually Transmitted Disease Program

GONORRHEA CASE REPORT FORM

PO Box 363, Trenton NJ 08625-0363 | 609-826-4869

****Lab Report MUST be submitted with this Case Report Form****

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE (indicate home, work or cell)	SEX AT BIRTH	CURRENT GENDER	IS PATIENT PREGNANT?	ESTIMATED DELIVERY DATE (If pregnant):
	☐Male ☐Female	☐Male ☐Female	☐Yes ☐No ☐Unknown	

ETHNICITY	RACE (Check all that apply)	GENDER OF SEX PARTNER(S)	REASON FOR EXAM (Check one)	DATE OF LAST HIV TEST:
☐Hispanic ☐Non-Hispanic ☐Unknown	☐White ☐Black ☐Asian ☐American Indian/Alaskan Native ☐Native Hawaiian/Other Pacific Islander ☐Other ☐Unknown	☐Male ☐Female ☐Both ☐Unknown	☐Symptomatic ☐Routine exam – no symptoms ☐Exposed to infection	RESULT: ☐Pos ☐Neg ☐Unk IS PATIENT ON PrEP? ☐Yes ☐No ☐Unknown

DIAGNOSIS

GONORRHEA (*MUST include lab report with this form)

SITE OF INFECTION (check all that apply):

☐Cervix ☐Urethra ☐Urine ☐Rectum

☐Pharynx ☐Vagina ☐Other:__________________

DATE TREATED:___________________________(check all treatments given)

☐Ceftriaxone 500mg IM ☐Ceftriaxone 1g IM ☐Azithromycin 2g

☐Doxycycline 100mg BIDx7 ☐Gentamicin 240mg IM ☐Cefixime 800mg

☐Other:____

WAS THE PATIENT GIVEN MEDICATION/PRESCRIPTION FOR THEIR PARTNER(S)? ☐Yes ☐No ☐Unk

DID PATIENT HAVE POSITIVE CHLAMYDIA LABS ALSO? ☐Yes ☐No ☐Unk

COMMENTS:

OTHER REPORTABLE STDs

If you want to report a case of **chancroid**, please call 609-826-4869 to discuss further.

REPORTING CLINIC INFORMATION

PERSON COMPLETING FORM	EXAMINING PROVIDER	DATE
(first) *(last)*	*(first)* *(last)*	

FACILITY NAME	TELEPHONE *(direct line)*

ADDRESS	ZIP CODE
(street) *(city)* *(state)*	

Thank you for reporting a STD. All information will be managed with the strictest confidentiality.

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