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

The State of New Jersey Department of Health
Sexually Transmitted Disease Program
CHLAMYDIA 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

☐ **CHLAMYDIA** (*MUST include lab report with the form)

SITE OF INFECTION (check all that apply):

☐Cervix ☐Urethra ☐Urine ☐Rectum

☐Pharynx ☐Vagina ☐Other:_____

DATE TREATED:_____ (check all treatments given)

☐Azithromycin 1g ☐Azithromycin 2g ☐Doxycycline 100mg BIDx7

☐Other:_____

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

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

☐ **LYMPHOGRANULOMA VEREREUM (LGV)** (*MUST include lab report with this form)

Verified: *Detection of LGV-specific antigen or nucleic acid in a clinical specimen. This includes asymptomatic cases.*
Likely: *Demonstration of C. trachomatis in a clinical specimen by detection of antigen or nucleic acid OR isolation of C. trachomatis by culture; AND who demonstrates clinical symptoms or signs consistent with LGV; AND has no negative test for LGV-specific antigen or nucleic acid in a clinical specimen.*

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 *(first)* *(last)*	EXAMINING PROVIDER *(first)* *(last)*	DATE

FACILITY NAME	TELEPHONE *(direct line)*

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

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