Sexually Transmitted Disease
Confidential Case Report Form
STD-23 (rev. 5/13/2016)

State of Connecticut
Department of Public Health

List of Reportable Sexually Transmitted Diseases

Chancroid	Chlamydia	Gonorrhea
Neonatal herpes (≤ 60 days of age)	Syphilis	

INSTRUCTIONS FOR SUBMITTING STD-23:

- This form is for reporting sexually transmitted diseases as required under Connecticut General Statute 19a-215, and Public Health Codes 19a-36-A2 through 19a-36-A4.
- If appropriate treatment has been provided, please complete the "Treatment Information" section of this form.
- STDs are considered category 2 diseases. This report must be completed and mailed in an envelope marked "CONFIDENTIAL" within 12 hours of recognition or strong suspicion of disease to:

1. Local Director of Health of town in which patient resides. (Canary) **AND** **2. State of Connecticut** (White)
Department of Public Health
410 Capitol Avenue, MS#11STD
P.O. Box 340308
Hartford, CT 06134-0308

If OUT OF STATE RESIDENT, submit both copies to the Department of Public Health (DPH) STD Control Program.

STD Supportive Services

Diagnostic, Treatment and Epidemiologic Consultation, Patient Referral Assistance, Partner Services, Professional Medical Reference and Resource Materials may be obtained by calling the DPH STD Control Program at:
(860) 509-7920

Forms may also be completed and FAXed to our office:
(860) 509-7275
AND
to the Local Health Department of the Patient's Residence.
The STD-23 and other reportable disease forms are available on our website: www.ct.gov/dph/forms.

Health Insurance Portability and Accountability Act (HIPAA) Guidelines

Pursuant to Connecticut General Statutes (CGS) § 19a-2a and § 19a-215, and to the Regulations of Connecticut State Agencies §s 19a-36-A3-4, the requested information is required to be provided to the DPH.

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
STD CONTROL PROGRAM
410 Capitol Avenue, MS#11STD
PO Box 340308
Hartford, CT 06134-0308

☐ **Note**: Check this box to request forms

PATIENT INFORMATION

Name (Last)	(First)	(MI)	Date of Birth	Home Phone Number	Other Phone Number

Address (Number and Street)	(City or Town)	(State)	(Zip Code)

Sex ☐ Male ☐ Female ☐ Unknown

Pregnant ☐ Yes ☐ No ☐ Unknown

Marital Status ☐ Married ☐ Single ☐ Unknown

Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other, specify: _____ ☐ Unknown

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Sex of Partners ☐ Men ☐ Women ☐ Both ☐ Unknown

Insurance Status ☐ Private ☐ Medicaid ☐ None ☐ Other

DISEASE INFORMATION

☐ **Gonorrhea** **OR** ☐ **Chlamydia**

- ☐ Symptomatic Uncomplicated
- ☐ Asymptomatic
- ☐ Pelvic Inflammatory Disease
- ☐ Other, specify:_____

☐ **Syphilis**

- ☐ Primary (Chancre Present)
- ☐ Secondary (Rash, Lesions, etc.)
- ☐ Early Latent – No SX (Duration < 1 Year)
- ☐ Late Latent – No SX (Duration > 1 Year)
- ☐ Late – With SX
- ☐ Congenital

☐ **Other STDs**

- ☐ Neonatal Herpes (≤ 60 days of age)
- ☐ Chancroid

PARTNER NOTIFICATION SERVICES

Providers treating STDs are expected to counsel patients in prevention and identify and refer partners to medical care for examination and treatment.

- ☐ Partners referred for exam and treatment by provider.
- ☐ Expedited Partner Therapy provided.
- ☐ Provider requesting assistance with partner notification from state health department. Please inform patient of this notification.

TREATMENT INFORMATION

Treatment Date: _____

☐ Not Treated

Specify Antibiotic and Dosage:

_____

_____

_____

DIAGNOSTIC INFORMATION

Test Date: _____

- ☐ Laboratory Confirmed
- ☐ Clinical Diagnosis-No Lab. Confirmation

Reporting Laboratory: _____

Results or attach lab report: _____

ATTENDING PHYSICIAN INFORMATION

Name:_____ Address:_____ Phone Number:_____ Date Reported:_____

If reporting from a Hospital or Facility, please complete the following: Name of person reporting (if different than above) _____

Name of Hospital or Facility:_____ ☐ Inpatient ☐ ER/Urgent Care ☐ Outpatient Clinic ☐ OB/GYN ☐ Family Planning

DISTRIBUTION - WHITE (A) – State Health Department CANARY (B) – Local Health Department PINK (C) – Submitter's Copy