CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD

Address: Phone: City: COUNTY of RESIDENCE: STATE, if not MT: Zip: Age: Sex: M F Race: White [] American Indian [] Black] Asian] Other [] Unknown] SPECIMEN COLLECTONUCLINICAL C-Fill In ALL text fields and mark variables for complete specimen collection Information on patient. Significant [] Significant [] Name of Lab Performing Test: Other [] Test Type: Test Source: Date Lab Specimen Collected: Test Type: Test Source: Date Lab Report Received: Date Reported to Health Department: Patient Diagnosis: Chianydia [] Syphilis * Profig.mar. Yes [] No [] Provider's Address: Phone: Provider's Address: Phone: Patient Timerower: Date: In date & mark or fill in text for treatment information at minimum. Date: Med: Dose: 1 gm [] Duration: X 1 [] Date: Med: Dose: 1 gm [] Duration: Contract: mane(2); CONTACT INFORMATION e>Fill in date & mark or fill in text for treatment information. Fill in text fields and due this section. Interviewing Agency: CodeRequind C CodeRegater Additional contact and coll	PATIENT INFORMATION				⇒Fill in ALL text fields and <u>mark</u> variables for complete demographic information as required by CDC.						
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