



## MORBIDITY REPORT for SEXUALLY TRANSMITTED DISEASES

New Mexico Revised Statutes 12-3-5, 1, Health Department Regulations Art. 1, 24-1-7 and New Mexico Administrative Code 7.4.3.13 require that patients with laboratory confirmed chlamydia, syphilis and gonorrhea be reported to the New Mexico Department of Health, STD Program within 24 hours.

PATIENT NAME – Last		First	Middle	SEX	DOB																																				
STREET ADDRESS			TOWN/CITY	STATE	COUNTY																																				
PHONE (Home)		(Work)	(Message)																																						
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNKNOWN																																									
RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> NATIVE AMERICAN (Tribe) _____ <input type="checkbox"/> ASIAN <input type="checkbox"/> MULTI-RACIAL <input type="checkbox"/> OTHER _____ <input type="checkbox"/> UNKNOWN			ETHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> UNKNOWN																																						
<b>DISEASE BEING REPORTED</b> <input type="checkbox"/> <b>GONORRHEA</b> <input type="checkbox"/> UNCOMPLICATED ASYMPTOMATIC <input type="checkbox"/> UNCOMPLICATED SYMPTOMATIC <input type="checkbox"/> SALPINGITIS <input type="checkbox"/> EPIDIDYMITIS <input type="checkbox"/> DISSEMINATED (ARTHRITIS) <input type="checkbox"/> OPHTHALMIA																																									
		<input type="checkbox"/> <b>SYPHILIS</b> <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY <input type="checkbox"/> EARLY LATENT (< 1 YEAR) <input type="checkbox"/> LATE LATENT (> 1 YEAR) <input type="checkbox"/> NEURO <input type="checkbox"/> CONGENITAL <input type="checkbox"/> FETAL DEATH <input type="checkbox"/> OTHER (SPECIFY) _____		<input type="checkbox"/> <b>CHLAMYDIA</b> PID <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> <b>CHANCROID</b>  <input type="checkbox"/> <b>OTHER STD:</b> _____																																					
SYMPTOMS (describe)	SYMPTOM ONSET (DATE)	SPECIMEN SOURCE <input type="checkbox"/> BLOOD/SERUM <input type="checkbox"/> CSF <input type="checkbox"/> URINE <input type="checkbox"/> URETHRA <input type="checkbox"/> CERVIX <input type="checkbox"/> RECTUM <input type="checkbox"/> THROAT <input type="checkbox"/> GENITALIA <input type="checkbox"/> LESION _____ <input type="checkbox"/> OTHER _____																																							
NAME OF FACILITY WHERE PATIENT WAS DIAGNOSED			NAME & TITLE OF ORDERING CLINICIAN		DATE OF REPORT																																				
FACILITY STREET ADDRESS			TOWN/CITY	STATE	ZIP																																				
NAME OF INDIVIDUAL COMPLETING THIS REPORT		PHONE	FAX	EMAIL																																					
WAS DIAGNOSIS CONFIRMED BY LABORATORY? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF LABORATORY																																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">TREATMENT</th> <th colspan="3">LAB RESULTS</th> </tr> <tr> <th>DATE</th> <th>DRUG</th> <th>DOSAGE</th> <th>COLLECTION DATE</th> <th>TEST TYPE</th> <th>TEST RESULTS</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>			TREATMENT			LAB RESULTS			DATE	DRUG	DOSAGE	COLLECTION DATE	TEST TYPE	TEST RESULTS																									YES   NO   UNK IS PATIENT PREGNANT? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ESTIMATED DUE DATE _____ IS PATIENT'S SPOUSE PREGNANT? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HAVE YOU EXAMINED SPOUSE? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HAVE YOU EXAMINED OTHER PARTNERS? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DO YOU WANT PT FOLLOW-UP BY HD? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
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PHYSICIAN COMMENTS:																																									
<b>PLEASE FAX COMPLETED FORM TO:</b> <b>505-476-3638</b>			<b>For Consultation call: 505-476-3636, (505) 476-3611. or (505) 476-1778</b> This form is available electronically at: <a href="http://www.health.state.nm.us/std.html">www.health.state.nm.us/std.html</a>																																						