CONFIDENTIAL
COMMUNICABLE DISEASE REPORTING FORM (STDs)

Ashland County-City Health Department
1763 St. Rt. 60 Ashland, OH 44805
(419) 282-4357
Fax (419) 282-4271

Patient's Name (include middle initial) :				
Date of Birth	Age	Race: Hispanic? Y / N		Sex: Male Female
Street Address			Parent's Name: (for minors)	
City	State	Zip	Phone #	
Patient pregnant? Yes No	If so, due date:		Reason for testing:	
Patient symptomatic? Yes No	Onset date:		Symptoms:	

Disease reported:

☐ Chlamydia	☐ Gonorrhea	☐ Syphilis	Other:

Please attach a copy of the lab report or complete lab information below:

Lab Company: _____ Address: _____ Specimen #: _____ Test Name: _____ Results: _____	Site: Cervix Vagina Urethra Urine Blood (circle) Other: _____ Collect date: _____ Result date: _____ Follow-up testing scheduled for _____ (complete new report for positive repeats)

Patient treated? Yes No Date started: _____ Disease info provided to pt.? Yes No
Treatment (include dose, how long, etc.): _____
Allergies:

Contact name:	Relationship:	Tested? Yes No Results Pos Neg	Treated? Yes No
Contact name:	Relationship:	Tested? Yes No Results Pos Neg	Treated? Yes No

Is there any reason that the Health Department should *not* contact the patient directly? Yes No
Explain:

Additional info or comments:

Reporting facility: _____ Provider's name: _____ Address: _____ _____	Report Completed By: _____ Phone: _____

Please fax or mail this report to the Ashland County-City Health Department