

STD MORBIDITY CARD

CONFIDENTIAL CASE REPORT

Last Name:		First Name:		Date of Birth:		Age:	
Address:				City:		State:	Zip:
County:		Phone #1:		Phone #2:			
Gender: <i>(check one)</i> <input type="checkbox"/> M <input type="checkbox"/> F		Race: <i>(check all that apply)</i> <input type="checkbox"/> White <input type="checkbox"/> Black/Af. Am <input type="checkbox"/> American Indian <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Native Hawaiian or Pacific Islander			Ethnicity: <i>(check one)</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown		
Disease:				Date of Onset:			
Name of Laboratory:			Specimen Source:		Date of Lab Test:		
Name of Attending Physician:					Phone:		
Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N		EDC:					
Treatment(s) & Dosage Given:					Date:		
Partner Name:		Date of Birth:		Age:	Sex:	Phone:	
Address:				City:		State:	Zip:
Treatment(s) & Dosage Given:					Date Given:		
Partner Name:		Date of Birth:		Age:	Sex:	Phone:	
Address:				City:		State:	Zip:
Treatment(s) & Dosage Given:					Date Given:		
Partner Name:		Date of Birth:		Age:	Sex:	Phone:	
Address:				City:		State:	Zip:
Treatment(s) & Dosage Given:					Date Given:		
Notes:							
Name of Person Reporting:					Date Reported:		
Agency:					Phone:		
A completed form may be mailed or faxed. The information may also be called in. A detailed message may be left on our confidential voice mail.							
Phone with confidential voice mail Tracy Harding 801-851-7057 or Kristine Black 801-851-7041					Confidential fax 801-851-7539		