GONORRHEA CASE INVESTIGATION RECORD

Local ID:	State ID:

REPORT INFORMATION:

Date of Specimen Collection	Date Lab Report Rec'd	Date CMR Rec'd

Patient Name – Last	First	Date of Birth	Age	Sex (M/F/ TG-MTF/TG-FTM/U)

Street Address	City	County/LHJ	Zip

Home Phone	Cellular Phone	Other Phone

Date CIR Assigned to Interviewer	Case Assigned to (enter interviewer # or initials)

LABORATORY INFORMATION:

Laboratory Name	Street Address

City	State	Zip	Phone Number

Site Tested	GC Test Type	GC Result	Site Tested	GC Test Type	GC Result
1. Site Tested:	☐ NAAT ☐ Culture ☐ Other	☐ Pos ☐ Inconcl ☐ Neg ☐ Unsat	2. Site Tested:	☐ NAAT ☐ Culture ☐ Other	☐ Pos ☐ Inconcl ☐ Neg ☐ Unsat
3. Site Tested:	☐ NAAT ☐ Culture ☐ Other	☐ Pos ☐ Inconcl ☐ Neg ☐ Unsat	4. Site Tested:	☐ NAAT ☐ Culture ☐ Other	☐ Pos ☐ Inconcl ☐ Neg ☐ Unsat

PROVIDER INFORMATION:

Provider Name	Facility Name	Provider Phone

Address	City	Zip	Provider Fax

Date PRF Sent to Provider

Method of PRF Data Collection *(check all that apply)*

☐ Phone ☐ Fax ☐ Chart review by public health staff ☐ CMR only

If PRF not completed - explain *(check one only)*

☐ Unable to contact provider w/in 30 days/3 attempts

☐ Other:___________________________________

CMR Status *(to be completed at time final disposition is assigned)*

☐ CMR rec'd prior to requesting PRF ☐ PRF accepted instead of CMR (if applicable)

☐ CMR rec'd after requesting PRF ☐ CMR not rec'd by Last Day to Interview Case

CASE CONTACT LOG:

Last Day to Interview Case

Six attempts must be made to contact each case; two of these attempts must be in the evening (5-8pm) and two on the weekend.
Each case must be contacted within 8 weeks of their diagnosis date (or closest available date if date of diagnosis is not available).

Contact Attempts *circle*

1. Date(mm/dd/yy): ___________ Time of Day (hh:mm)_______am/pm
2. Date(mm/dd/yy): ___________ Time of Day (hh:mm)_______am/pm
3. Date(mm/dd/yy): ___________ Time of Day (hh:mm)_______am/pm

circle

4. Date(mm/dd/yy): ___________ Time of Day (hh:mm)_______am/pm
5. Date(mm/dd/yy): ___________ Time of Day (hh:mm)_______am/pm
6. Date(mm/dd/yy): ___________ Time of Day (hh:mm)_______am/pm

** **FINAL DISPOSITION** ***(check one only)*** **

Patient interviewed:

☐ Completed interview (1)

☐ Incomplete interview (2)

Patient contacted but not interviewed:

☐ Refused interview (3)

☐ Language barrier (does not speak English or Spanish) (4)

Patient not contacted:

☐ Unable to reach patient after 6 attempts (6)

☐ Unable to contact patient within 8 weeks of date of specimen collection (7)

☐ Bad/no locating information (8)

No attempt made to contact patient:

☐ Case not a resident of LHJ at time of diagnosis (10)

☐ Case previously diagnosed within past 30 days (11)

☐ Case less than 14 years of age (12)

☐ Case identified more than 8 weeks after date of specimen collection (13)

☐ Provider requested that the patient not be contacted (14)

Other final disposition: *Please note that "Other" should only be selected if none of the specific final dispositions apply. Please be brief.*

☐ Other (16): ____

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El Centro, CA 92243

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PROVIDER REPORT FORM (PRF)

We are following up on gonorrhea cases to help ensure adequate treatment of patients and their partners. As a component of this effort, we are requesting information from you (the provider) or your representative. Please fill out this form for the following patient and return within 48 hours of receipt. If you have any questions, feel free to call us at (760) 482-4723.

When complete, please fax this form to (760) 482-4738

Patient Name: ______________________________ **Date of Birth:** ______________________________

☐ We have received a CMR. Please complete the missing information below and update as necessary.
☐ We have not received a CMR. Please fill out the information below.

PATIENT INFORMATION:

	Local ID:	State ID:

Street Address ☐ Homeless

City | **Zip**

Phone #

Gender
☐ Male
☐ Female
☐ TG - MTF
☐ TG - FTM
☐ Unknown

Ethnicity
☐ Hispanic/Latino ☐ non-Hispanic/Latino ☐ Unknown

Race *(check all that apply)* ☐ Unknown
☐ White ☐ Native Hawaiian/Pacific Islander
☐ Black ☐ American Indian/Alaska Native
☐ Asian ☐ Other: ____________________

Type of Facility? *(check one only)*

☐ Private physician/HMO	☐ Planned Parenthood/family planning	☐ Military/VA	☐ Hospital inpatient
☐ STD Clinic	☐ Community/PH Clinic (non-STD/non-HIV)	☐ Urgent Care	☐ Hospital outpatient
☐ HIV Clinic	☐ Correctional	☐ ER	☐ Other: __________________________

MEDICAL INFORMATION:

Date of VISIT ____________________

Date of DIAGNOSIS _______________

1. Pregnant? *(if female)*
☐ Yes ☐ No ☐ Unk

2. Patient co-diagnosed with chlamydia?
☐ Yes ☐ No ☐ Not tested ☐ Unk

3. Source of the specimen(s) tested for gonorrhea? *(check all that apply)*
☐ Unknown ☐ Not tested
☐ Urine ☐ Vagina ☐ Anus/Rectum
☐ Cervix ☐ Urethra/Penis ☐ Throat
☐ Other: ____________________

4. Did the patient have signs/symptoms of a gonorrhea infection? ☐ Yes ☐ No ☐ Unknown

Date of ONSET _____________________

→ **IF YES, which symptoms?** *(check all that apply)* ☐ Unknown ☐ Rectal symptoms
☐ Abnormal vaginal discharge (F) ☐ Pelvic/abdominal pain (F) ☐ Testicular pain/discomfort (M) ☐ Sore throat
☐ Abnormal vaginal bleeding (F) ☐ Penile discharge (M) ☐ Burning/pain on urination ☐ Other: ______________________

5. Does this patient have sex with:
☐ Men ☐ Women ☐ Both ☐TG ☐ Unk

6. Provided patient with medication or prescription for his/her partners? ☐ Yes ☐ Unk
☐ Never offer PDPT for GC ☐ Did not offer this patient PDPT ☐ Offered, but not accepted

7. With which drug(s) and dosage(s) was the patient treated for this episode of gonorrhea, including any co-treatment for chlamydia?

☐ Not treated ☐ Treatment status unknown

Drug *(check all that apply)*	**Dosage**		**Treatment Date** *(mm/dd/yyyy)*
☐ Ciprofloxacin (Cipro)…….	☐ 500 mg PO………………………………………...	☐ Other dosage:_______	______/______/__________
☐ Cefixime (Suprax)…..……	☐ 400 mg tab PO…..☐ 400 mg suspension PO…...	☐ Other dosage:_______	______/______/__________
☐ Ceftriaxone (Rocephin)....	☐ 125 mg IM..................☐ 250 mg IM....................	☐ Other dosage:_______	______/______/__________
☐ Cefpodoxime (Vantin)…...	☐ 400 mg PO………………..……………………..…..	☐ Other dosage:_______	______/______/__________
☐ Azithromycin (Zithromax).	☐ 1000 mg (1gm) PO….. ☐ 2000 mg (2gm) PO…...	☐ Other dosage:_______	______/______/__________
☐ Doxycycline……………...	☐ 100 mg PO bid x7 days...☐x10 days...☐x14 days...	☐ Other dosage:_______	______/______/__________
☐ Other:_______________	☐ Other dosage:________________________		______/______/__________

All reported information will be maintained in the strictest confidence. Reporting of gonorrhea is required under California Code Regulations, Title 17, Section 2500 and does not violate HIPAA regulations

CONFIDENTIALITY NOTE:

The information in this facsimile includes confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this facsimile is strictly prohibited and may result in civil and criminal penalties under the California and/or federal law. If you have received this facsimile in error, please immediately notify us at the telephone number listed above.

PATIENT INTERVIEW

Local ID: State ID:

A. Gender (self-report) ☐ Male ☐ Female ☐ TG-MTF ☐ TG-FTM U R

B. Age (self-report) _____ U R

C. Hispanic/Latino? Y N U R

D. Race *(check all that apply)*
☐ White ☐ Black ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other: _______________ U R

E. Country of Birth? ☐ USA ☐ Mexico ☐ Other: _________________________ U R

F. Highest level of education completed? ☐ Less than HS grad/less than GED ☐ Some college/trade school ☐ Graduate degree ☐ HS grad/GED ☐ 4 yr degree U R

G. Are you a student at this time? ☐ No, not a student ☐ Yes, part-time student ☐ Yes, full-time student U R

H. What is your employment status at this time? ☐ Employed ☐ Homemaker ☐ Out of work < 1 year ☐ Unable to work ☐ Self-employed ☐ Retired ☐ Out of work > 1 year U R

I. At the time you were tested for gonorrhea, what was the **main** reason that you sought care from the provider who tested you?
☐ It was my usual place for medical care ☐ Costs less ☐ Expert care
☐ Ability to do walk-in/same day appt ☐ Privacy concerns ☐ Other, please specify ___________________

J. Do you have any kind of health care coverage or insurance?
Y N U R

K. Is your insurance a private health insurance or publicly-funded health insurance, such as Medi-Cal?
☐ Private health insurance ☐ Government health insurance U R

L. Did you have to pay a co-pay when you were diagnosed with gonorrhea? Y N U R

M. Did you have symptoms at the time of your GC diagnosis? Y N U R

N. Pregnant at the time of GC diagnosis? *(females only)* Y N U R

O. Was one of the reasons you were tested because someone told you that you may have been exposed to gonorrhea? Y N U R
→ **IF YES**, who? ☐ Partner ☐ Health Department ☐ Other U R

P. At the time of your GC diagnosis, were you also diagnosed with: Chlamydia? Y N U R PID? Y N U R

Q. Before this gonorrhea infection, have you ever been diagnosed with any of the following?
Gonorrhea Y N U R → IF YES, in previous 12 months? Y N U R
Chlamydia Y N U R → IF YES, in previous 12 months? Y N U R
Syphilis Y N U R → IF YES, in previous 12 months? Y N U R

R. Have you completed the vaccination series for:
Hepatitis B Y N U R
Hepatitis A Y N U R

S. Have you ever had an HIV test? Y N U R
→ **IF YES**, month/year of last test:________________ U R
Test result: ☐ Positive ☐ Pending ☐ Inconclusive/discordant/invalid ☐ Other:____________________
☐ Negative ☐ Preliminary positive ☐ Didn't return to get result U R
→ **IF POSITIVE**, would you like someone to contact you regarding HIV services? ☐ Yes ☐ No, already in care ☐ No, not interested U R
→ **IF POSITIVE**, would you like someone to contact you regarding help in notifying your partners? Y N U R

T. In the past **12 months** have you had sex with men, women or both? ☐ Men ☐ Women ☐ Both ☐ TG U R

U. In the **3 months** prior to your GC diagnosis:
How many **male** partners did you have? ______
How many of these were new? ______ anonymous? ______
How many **female** partners did you have? ______
How many of these were new? ______ anonymous? ______
How many **transgender** partners did you have? ______
How many of these were new? ______ anonymous? ______

V. Is it likely that any of your sex partners in the **3 months** preceding your gonorrhea diagnosis had sex (of any type) with someone else while they were still in a sexual relationship with you?
☐ Yes, definitely ☐ No, it is very unlikely
☐ It is possible/unsure U R

PATIENT INTERVIEW *(continued)*	Local ID:	State ID:

The next several questions are about the **12 months** prior to your gonorrhea diagnosis.

Name(s) of venues

W. VENUES - Did you meet any new and/or anonymous partners at:

		Name(s) of venues
Bars/clubs?	Y N U R	____________________
Baths/spas/sex clubs?	Y N U R	____________________
Internet/chatrooms/email?	Y N U R	____________________
Other(s)?	Y N U R	____________________

X. RISK FACTORS & SOCIAL HISTORY

Gave money/drugs for sex?	Y N U R
Received money/drugs for sex?	Y N U R
Injected any recreational drugs?	Y N U R
Any gang association?	Y N U R

→ **IF YES**, gang name:________________________

Y. SUBSTANCE USE Y N U R

Methamphetamine	Y N U R
Nitrates/Poppers	Y N U R
Crack/cocaine	Y N U R
Viagra or other similar drugs	Y N U R
Other (not alcohol or marijuana)	Y N U R ____________________

Z. INCARCERATION - In the **12 months** prior to your GC diagnosis, have you:

Been in a jail/juvenile detention facility?	Y N U R
Been in a prison/long-term correctional facility?	Y N U R

In the **12 months** prior to your gonorrhea diagnosis:

AA. Were any of your sex partners in a jai/ juvenile detention facility, or prison/long-term correctional facility? Y N U R

BB. Did any of your sex partners use meth/speed? Y N U R

Now think back to the **<u>last person you had sex with before you were tested</u>** for gonorrhea. The next questions are about this sex partner.

CC. How old was this sex partner? ________ U R

DD. Was this partner: ☐ Male ☐ Female ☐ TG-MTF ☐ TG-FTM U R

EE. Was this partner HIV positive? Y N U R

FF. Was this partner Hispanic? Y N U R

GG. What was the race of this partner? *(check <u>one</u> only)* U R

☐ White ☐ Black ☐ Asian ☐ Native Hawaiian/Pacific Islander

☐ American Indian/Alaska Native ☐ Other ____________________

HH. Before you were tested for gonorrhea, did you use a condom the last time you had anal or vaginal sex with this partner? Y N U R ☐ N/A

II. Have you had sex with this partner since you were tested for gonorrhea? Y N U R

JJ. How sure are you that this partner got treated? ☐ Sure partner got treated ☐ Don't know/unsure ☐ Sure partner did NOT get treated U R

KK. The following question refers to any partners: Were you GIVEN medication or a prescription to give to your partner(s)?

☐ Yes ☐ Medication/prescription not offered to me ☐ No, because partner already treated ☐ Refused for OTHER reason U R

INTERVIEWER NOTES:

Interview Date (mm/dd/yyyy)	Start time	Stop time	Interview method	Interview conducted in jail/prison?
	am/pm	am/pm	☐ Phone ☐ In person	☐ Yes ☐ No

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____ **COMPLETE FINAL DISPOSITION (ON FIRST PAGE)**