KANSAS SEXUALLY TRANSMITTED INFECTION CASE REPORT FORM
In accordance with K.S.A. 65-118, 65-128, 65-6001 - 65-6007, K.A.R. 28-1-2, 28-1-4, and 28-1-18.

Today's Date:		**Patient's DOB:**			
Patient's Name:	(Last)	(First)	(Middle)		
Home Phone:		**Work Phone:**		**Cell Phone:**	
Residential Address:					
City:		**State:**		**Zip Code:**	

Ethnicity:	**Race:**	
☐Hispanic or Latino	☐ American Indian/Alaska Native	☐ Native Hawaiian/Pacific Islander
☐Not Hispanic or Latino	☐ Asian	☐ White
☐Unknown	☐ Black/African-American	☐ Unknown

Gender:	☐ Male	☐ Female	☐ Transgender

Pregnancy Status: (Females Only)	**HIV Status:**	**Gender of Sex Partners:** (check all that apply)	
☐ Yes	☐ Negative	☐ Male	☐ Unknown/Did Not Ask
☐ No	☐ Positive	☐ Female	
☐ Unknown	☐ Unknown/Did Not Ask	☐ Transgender	

Infection Being Reported: (check all that apply)	**Physician Name:**	**Physician Phone:**
☐ Chlamydia		
☐ Gonorrhea	**Name of Person Reporting:**	**Phone of Person Reporting:**
☐ Syphilis		

Laboratory Information

Name of Laboratory:	**Name of Test Performed:**	
Specimen Collection Date:	**Results of Test:**	**Date Reported to You:**

TREATMENT INFORMATION

Date of Treatment:	

Treatment Type and Dosage:

☐ Ceftriaxone 500mg	☐ Azithromycin 1g
☐ Benzathine Pencillin G L.A 2.4 mu	☐ Benzathine Pencillin G L.A. 2.4mu X 3
☐ Doxycycline 100mg BID x 7 days	☐ Other: **Please specify drug & dosage:**

Please fax reports to the Kansas Department of Health & Environment, STI/HIV Section at:
Fax: 785-559-4225 Phone: 785-296-6174

Rev 2021-03-24