MORBIDITY REPORT for NEW MEXICO DEPARTMENT OF HEALTH SEXUALLY TRANSMITTED DISEASES

New Mexico Revised Statutes 12-3-5, 1, Health Department Regulations Art. 1, 24-1-7 and New Mexico Administrative Code7.4.3.13 require that patients with laboratory confirmed chlamydia, syphilis and gonorrhea be reported to the New Mexico Department of Health (NMDOH) STD Program within 24 hours.

PATIENT NAME – Last	First	Middle	**SEX**	**DOB**

STREET ADDRESS	**TOWN/CITY**	**STATE**	**COUNTY**	**ZIP CODE**

PHONE (Home)	(Work)	(Message)

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WID0WED ☐ UNKNOWN

RACE
☐ WHITE ☐ BLACK ☐ NATIVE AMERICAN (Tribe)_____ ☐ ASIAN
☐ MULTI-RACIAL ☐ OTHER _____ ☐ UNKNOWN

ETHNICITY
☐ HISPANIC ☐ NON-HISPANIC
☐ UNKNOWN

DISEASE BEING REPORTED

☐ **GONORRHEA**
- ☐ UNCOMPLICATED ASYMPTOMATIC
- ☐ UNCOMPLICATED SYMPTOMATIC
- ☐ SALPINGITIS
- ☐ EPIDIDYMITIS
- ☐ DISSEMINATED (ARTHRITIS)
- ☐ OPHTHALMIA

☐ **SYPHILIS**
- PRIMARY
- SECONDARY
- EARLY LATENT (< 1 YEAR)
- LATE LATENT (> 1 YEAR)
- NEURO
- CONGENITAL
- FETAL DEATH
- OTHER (SPECIFY) _____

☐ **CHLAMYDIA**
PID ☐ Yes ☐ No

☐ **CHANCROID**

☐ **OTHER STD:** _____

SYMPTOMS (describe)	**SYMPTOM ONSET (DATE)**	**SPECIMEN SOURCE** ☐ BLOOD/SERUM ☐ CSF ☐ URINE ☐ URETHRA ☐ CERVIX ☐ RECTUM ☐ THROAT ☐ GENITALIA ☐ LESION_____ ☐ 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?
☐ YES ☐ NO

NAME OF LABORATORY

TREATMENT			**LAB RESULTS**		
DATE	**DRUG**	**DOSAGE**	**COLLECTION DATE**	**TEST TYPE**	**TEST RESULTS**

	YES	NO	UNK
IS PATIENT PREGNANT?	☐	☐	☐
ESTIMATED DUE DATE _____			
IS PATIENT'S SPOUSE PREGNANT?	☐	☐	☐
HAVE YOU EXAMINED SPOUSE?	☐	☐	☐
HAVE YOU EXAMINED OTHER PARTNERS?	☐	☐	☐
DO YOU WANT PT FOLLOW-UP BY HD?	☐	☐	☐

WAS EPT (EXPEDITED PARTNER THERAPY) PROVIDED FOR YOUR PATIENT'S SEXUAL PARTNER(S)?
Yes ◯ No ◯

IF EPT WAS PROVIDED HOW MANY DOSES WERE GIVEN? _____

FOR MORE INFORMATION ON EXPEDITED PARTNER THERAPY IN NEW MEXICO PLEASE GO TO http://nmhealth.org/IDB/ept.shtml OR CALL (505) 476-1778 FOR ADDITIONAL INFORMATION.

PHYSICIAN COMMENTS:

PLEASE FAX COMPLETED FORM TO:
505-476-3638

For Consultation call: (505) 476-3636 or (505) 476-3611
This form is available electronically at:
http://nmhealth.org/about/phd/idb/std/

Revised June 2014