Wyoming Department of Health:
STD/HIV/VIRAL HEPATITIS DISEASE REPORTING FORM

DATE REPORTING_____

DEMOGRAPHICS

NAME: Last _____ First _____MI_____
PREFERRED NAME/AKA _____ Maiden_____

GENDER: ☐ M ☐ F ☐ T **AGE:** _____ **DATE OF BIRTH:**_____
PHONE: Home/Cell_____Work:_____ Email: _____

ADDRESS: Street:_____ City: _____ State: _WY__ Zip:_____

CURRENTLY INSTITUTIONALIZED: ☐ Y ☐ N Facility Name: _____
COUNTRY OF BIRTH (If reporting HIV/AIDS): _____

MARTIAL STATUS:
☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Domestic Partner ☐ Unknown

RACE:
☐ American Indian/Alaska Native ☐ Asian ☐ Refused
☐ Black or African American ☐ White/Caucasian
☐ Pacific Islander/Native Hawaiian ☐ Unknown

ETHNICITY:
☐ Hispanic/Latino ☐ Non-Hispanic/Latino
☐ Unknown ☐ Refused

PREGNANCY: ☐ Y (Due Date: _____) ☐ N ☐ Unknown

ENGLISH SPEAKING: ☐ Y ☐ N ☐ Unknown
Primary Language:_____

LABORATORY INFORMATION

Reporting Laboratory Facility: _____
Address: _____City: _____ State: _____Zip:_____
Person Reporting:_____ Phone:_____
Specimen Source: _____ Collection Date:_____ Result Date:_____

PROVIDER INFORMATION

Reporting Provider: _____
Clinic: _____ City: _____ State: _WY_ Zip:_____
Person Reporting:_____ Phone: _____Fax: _____

SEXUALLY TRANSMITTED DISEASE AND VIRAL HEPATITIS DISEASE (*Please check disease being reported*)

☐ Chlamydia ☐ Gonorrhea ☐ Treated not tested
☐ Syphilis:*(circle)Primary, Secondary, Early latent (<1 yr), late latent (>1yr)*
☐ HIV/AIDS: Test(s) conducted: _____

☐ Hepatitis B → (SELECT ONE) ☐ Acute ☐ Chronic, Newly Diagnosed ☐ Chronic, Previously Diagnosed
☐ Hepatitis C → (SELECT ONE) ☐ Acute ☐ Chronic, Newly Diagnosed ☐ Chronic, Previously Diagnosed
(Also include hepatitis panel and liver function lab results with report)

REASON FOR SCREENING: _____
OPPORTUNISTIC INFECTION (If HIV/AIDS): _____

ONSET DATE OF SYMPTOMS OR DIAGNOSIS DATE OF CHRONIC CONDITION:
_____

PATIENT TREATMENT OR PLAN OF CARE (Medication given, date of treatment, referrals made): _____
_____

SYMPTOMS ☐ Pelvic Pain ☐ Clay-colored Stool ☐ Jaundice ☐ Night Sweats
☐ Fever ☐ Penile Pain ☐ Dysuria ☐ Rash ☐ Abnormal Bleeding
☐ Lesion ☐ Discharge ☐ Other (list): _____

PARTNER TREATMENT (Partner name(s), medication given, date of treatment):
_____

PROVIDE DATE AND RESULTS OF OTHER TESTS DONE (HIV, Chlamydia, Gonorrhea, Syphilis, Hepatitis B or C):_____
_____

RISK FACTORS _____ # of sex partners (lifetime) _____ # of sex partners (<90 days) Sex with Injection Drug User? ☐ Yes ☐ No ☐ Unknown

Sex with:	☐ Male ☐ Female ☐ Both ☐ Anonymous Partner	Injection Drug Use (Even Once)	☐ Yes ☐ No ☐ Unknown ☐ Refused
Condom Use:	☐ Never ☐ Always ☐ Sometimes ☐ Refused	Recent Surgery	☐ Yes ☐ No ☐ Unknown ☐ Refused
Body Piercing	☐ Yes ☐ No ☐ Unknown ☐ Refused	Blood Transfusion/ Organ Transplants	☐ Yes ☐ No ☐ Unknown ☐ Refused
Tattoo	☐ Yes ☐ No ☐ Unknown ☐ Refused	History of Incarceration	☐ Yes ☐ No ☐ Unknown ☐ Refused
Prior STD infection	☐ Yes, Specify:_____ ☐ No	Other _____	

THIS FORM CAN ALSO BE COMPLETED AND SUBMITTED ONLINE AT https://prismdata.health.wyo.gov/
Submit form to: Wyoming Department of Health Communicable Disease Section 6101 Yellowstone Road, Suite 510 Cheyenne, WY 82002
Secure Fax: (307) 777-5279 / Phone: (307) 777-7953
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