INSTRUCTIONS
SEXUALLY TRANSMITTED DISEASES CLINICAL ASSESSMENT FORM - DHHS 2808

Documentation of the STD assessment should tell the story of high-quality management of a presenting client complaint or need. All elements of required protocol for risk assessment, testing and management should be reflected in the record and support continuity of care among providers.

Items 1-6: Use computer generated label or manually complete all demographic information in these sections.

7. Allergies: List all pertinent allergies (e.g., drug, latex).

Date of Visit: Record the date of the client's current visit.

8. Reason(s) for Visit: Check all items that apply.

- **Symptoms** –
  - **1st visit** – Check this box if this is an initial visit for a specific complaint.
  - **Persistent** – Check this box if this is a return visit for unresolved complaint.

- **STD screen only: asymptomatic –** Check this box if the client presents without symptoms for a routine check-up.

- **Follow-up retest** – Check this box if client presents for the sole purpose of being retested per gonorrhea and Chlamydia post-treatment protocol.

- **Treatment –** Check this box if the client is presenting for treatment only for a ***positive test done at the health department.***

- **Contact to** – Check this box if client presents as a partner to someone diagnosed with an STD.

- **Partner with symptoms –** Check this box if client presents without symptoms and reports that a partner has symptoms. Example: Client may report a partner's symptoms or treatment but cannot identify the STD.

- **Referral from –** Check this box if client presents based on referral from other providers, i.e., DIS, MD.

  - **Test** – Check this box if client presents with a confirmed positive test that was ***not done at the health department.***

- **Symptoms/Symptom Parameters** – Check which symptoms are present or absent. Include the specific elements:

  - *Location* – site of symptom/complaint
  - *Quality* – color/consistency/amount, etc.
  - *Severity* – use scale of 1 – 10
  - *Duration* – date of onset or length of time complaint is present
  - *Associated signs/symptoms* – any other information relevant to signs and symptoms ***for the chief complaint***.

  If there are multiple symptoms with different parameters, clarify in section 13 (Comments).

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9. Prior STD Treatment – Check all that apply according to the patient's history, including syphilis titer and where treated if known.

- Document vaccines and HIV test dates if known.

10. Sexual Risk Assessment – Complete all parameters to include:

- Number of male and/or female partners within the past 60 days. (Do not assume sexual orientation)
- Date of last sexual encounter
- Client's anatomical sites of sexual exposure in past 60 days, i.e., mouth, penis, vagina, anus
- Number of sexual encounters in the last two weeks and the # of those encounters that occurred with use of a condom
- Other sex partner information as listed
- Document alcohol use and frequency
- Document use of injectable drugs and last injection
- Document use of other drugs

11. For Women Only – Document menstrual history, pap test date and results, douching practices, and contraceptive method.

12. Other Pertinent History – Document medications in last two weeks and current medication.

13. Comments – Use this section for additional risk and symptom information as needed.

14. Physical Examination – Document all components of the exam with description of abnormal findings.

- Omitted components should be noted in the relevant box as ***not done***.
- Male or female diagrams should reflect location of genital lesions observed during exam.
- Use "further description of findings" section if more room is needed.

NOTE*: Temperature and/or blood pressure may be documented if clinically indicated, i.e., client presents with signs of acute illness such as severe abdominal pain, scrotal pain, signs of allergic reaction to medication, etc.*

15. Laboratory – Check all laboratory procedures ordered. Document results of stat lab tests.

16. Clinical Impression – This section should correspond to Therapy section (#17). Check all that apply based on exam and lab findings and/or history.

NOTE*: STD screen is not a clinical impression. If there is no specific diagnosis, check the "other" box and explain.*

17. Therapy – This section should correspond to the Clinical Impression section. Check all treatment administered and/or prescribed. There should be a clinical impression documented that supports documented treatment.

18. Instructions/Counseling – Check all that apply to document patient teaching, test follow-up and other follow-up instructions, including referrals.

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Notes – Include important information not covered by the previous sections, especially information to enhance continuity of care if another provider sees the client on the next visit.

Primary Provider Signature – The provider examining and deciding the care plan for the patient should sign this section.

> ***NOTE****: Primary provider should check the box reflecting his/her discipline, i.e. Enhanced Role RN, NP, PA, or MD.*

Co-signature – This section is for preceptor or other *required* co-signature.

> ***NOTE:*** *RNs providing only the treatment should initial the medication provided.*

Time Enhanced Role RN spent with patient - Include minutes and units. (15 minutes = 1 unit)