Monterey County Health Department Communicable Disease Unit (CDU)
Referral for Sexually Transmitted Disease (STD) Partner Services

SECTION A – TO BE COMPLETED BY REFERRING PROVIDER'S OFFICE

Name of Referring Facility/Provider: _____ Phone: _____ Fax: _____

1. Original patient's (OP) information: Name (Last) _____ (First) _____
   Birth Date_____/_____/_____ Gender: □ Male □ Female □ Transgender M to F □ Transgender F to M □ Intersex

   Street Address _____ City _____ State ____ ZIP _____

   Phone # (Home) _____ (Cell) _____ (Work) _____

2. Type of STD with which the OP has been diagnosed (mark all that apply):
   □ Syphilis – Primary, Secondary, or Early Latent □ HIV □ AIDS
   □ Syphilis – Late or Latent of Unknown Duration □ Gonorrhea □ Chlamydia

3. High risk category to which the OP belongs (mark all that apply):
   □ Currently Pregnant (EDD: _____) □ History of ≥2 STDs within 12 Months
   □ Age 13 – 17 Years □ Exchanges Sex for Money, Food, Shelter, Drugs, and/or Clothing

4. Partner's information. If OP has multiple partners, please fill out one form for each partner.
   You must provide *at least* name <u>and</u> one valid method of contact. Fill out this section as completely as possible.

   Name (Last) _____ (First) _____ (Middle) _____ Jr. / Sr. / ____

   Birth Date or Age: _____ Gender: □ Male □ Female □ Transgender M to F □ Transgender F to M □ Intersex

   Street Address with Apt/Trailer #_____ City _____ State ____ ZIP _____

   Phone # (Home) _____ (Cell) _____ (Other) _____

   Email address: _____ Chat Room Venue & ID: _____

   Previous Names or A.K.A.s including Maiden Name: _____

   Description of Dwelling: _____ Description of Vehicle: _____

   Hangouts: _____ Workplace: _____ School: _____

   Height: _____ Size/Build: _____ Hair Color: _____ Complexion: _____

   Scars, Markings, Tattoos, Piercings, Glasses, Other Outstanding Features: _____

   Married? □ Yes □ No Pregnant? □ Yes □ No Race/Ethnicity? _____

   Date of First Contact with OP: _____ Frequency: _____ Date of Last Sexual Contact with OP: _____

5. Type of partner services requested (select one):
   □ Dual Disclosure (OP wishes to inform partner himself/herself with Health Department assistance)
   □ Anonymous Third Party Notification (Health Department will not disclose OP's identity to partner)

Upon completion of Section A, please fax this form
to the Monterey County Health Department's CDU at 831-754-6682.

Monterey County Health Department
Communicable Disease Unit (CDU)
Referral for Sexually Transmitted Infection (STD) Partner Services

SECTION B – TO BE COMPLETED BY HEALTH DEPARTMENT STAFF

1. Name of Referring Facility/Provider: _____

   Phone Number: _____ Fax Number: _____

   Date Referral Received: _____ Date Services Initiated: _____

2. Original patient (OP):

   Name (Last) _____ (First) _____ DOB: _____

3. Type of STD with which the OP has been diagnosed (mark all that apply):
   - □ Syphilis – Primary, Secondary, or Early Latent
   - □ Syphilis – Late or Latent of Unknown Duration
   - □ HIV
   - □ Gonorrhea
   - □ AIDS
   - □ Chlamydia

4. Partner for which services were requested:

   Name (Last) _____ (First) _____ DOB or Age: _____

   Email address: _____ Chat Room Venue with ID: _____ Phone #: _____

5. Disposition of referral:
   - □ Linked to services for testing and/or treatment
   - □ Insufficient information provided to attempt contact
   - □ Unable to locate
   - □ Located/notified but refused services
   - □ Located/notified but partner had already received services from another provider for this exposure
   - □ Other: _____

6. Contact attempts:
   - □ _____ □ _____
   - □ _____ □ _____

7. Comments: _____

   _____

   _____

8. Completed by:

   Name: _____ Title: _____

   Phone Number: _____ Date of Completion: _____