Strategies for Effective Chlamydia Screening
August 18, 2008

Dear Colleague:

The Iowa Department of Public Health (IDPH) STD Program has partnered with the Region VII Infertility Prevention Project (IPP) and the Saint Louis STD/HIV Prevention Training Center (PTC) to bring you “Strategies for Effective Chlamydia Screening”. This educational toolkit is aimed at increasing health care providers’ knowledge and skills to screen and prevent transmission for Chlamydia and other related infections in adolescents and young adults in an office-based setting.

The Centers for Disease Control and Prevention (CDC), U.S. Preventive Services Task Force (USPSTF), and leading medical organizations, including the American Academy of Pediatrics (AAP), the American Academy of Family Planning Physicians (AAFPP), the American College of Obstetricians and Gynecologists (ACOG), and the American Medical Association, all recommend routinely screening all sexually active women under the age of 26 for Chlamydia and gonorrhea. Annual Chlamydia screening is a Health Care Effectiveness Data Information Set (HEDIS) quality assurance measure. This toolkit was created to assist health care providers in confidential screening for Chlamydia and other related infections.

The “Strategies for Effective Chlamydia Screening” Toolkit includes:

- A sexual history questionnaire and accompanying provider information
- CDC Chlamydia Screening recommendations
- IDPH Communicable Disease Reporting Requirements
- Minor Consent guidance for STDs and HIV
- *Neisseria gonorrhoeae* and *Chlamydia trachomatis* laboratory testing information
- Patient education materials
- Confidentiality Tips
- Guidance on partner management options
- Free CME’s

The STD Program staff look forward to working with your practice on this collaborative quality improvement activity to increase Chlamydia screening and the quality of care for Iowa’s young patients.

Sincerely,

Karen Thompson,  
STD Program Manager

Kenneth Soyemi, MD, MPH  
Deputy State Epidemiologist
The “Strategies for Effective Chlamydia Screening” toolkit was possible because of contributions from the following individuals and entities:

**Primary Contributor Acknowledgements:**

- Heather Adams, JD – Assistant Attorney General, Iowa Attorney General’s Office
- Colleen Bornmueller, BS – Iowa Infertility Prevention Project Coordinator, Family Planning Council of Iowa
- Kenneth Cheyne, MD – Director of Pediatric Education, Adolescent Medicine, Blank Children’s Hospital
- Karla Johnson, MSPH – Executive Director, Region VII Infertility Prevention Project, Development Systems, Inc.
- Mary Jones, BSEMS, MA – Deputy Director, Iowa Department of Public Health
- Elizabeth Raasch, BA – STD Program Spring 2008 Intern, Iowa Department of Public Health
- Delores Rother, MPH – Program Manager, St. Louis STD/HIV Prevention Training Center
- Kenneth Soyemi, MD, MPH – Deputy State Epidemiologist, Iowa Department of Public Health
- Rick Steece, PhD, D(ABMM) – National Chlamydia Laboratory Coordinator, Centers for Disease Control and Prevention
- Bradley Stoner, MD, PhD – Medical Director, St. Louis STD/HIV Prevention Training Center
- Karen Thompson, BS – STD Program Manager, Iowa Department of Public Health

**Contributor Acknowledgements:**

<table>
<thead>
<tr>
<th>Diane Behle</th>
<th>Iowa Department of Public Health</th>
<th>Linda McQuinn</th>
<th>Iowa Department of Public Health</th>
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<tr>
<td>Shelley Collins</td>
<td>Coventry Health Care of Iowa</td>
<td>Joanne Parker</td>
<td>Iowa Commission on the Status of Women</td>
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<tr>
<td>Mary Costello</td>
<td>Iowa Department of Public Health</td>
<td>Rodney Pederson</td>
<td>Gen-Probe Incorporated</td>
</tr>
<tr>
<td>Vickie Evans</td>
<td>Wellmark BlueCross &amp; BlueShield of Iowa</td>
<td>Ann Rogers</td>
<td>Black Hawk County Health Department</td>
</tr>
<tr>
<td>Tanya Ferguson</td>
<td>Council Bluffs City Health Department</td>
<td>Kelly Rooney-Kozak</td>
<td>Iowa Department of Public Health</td>
</tr>
<tr>
<td>Carol Hausrath</td>
<td>Roche Diagnostic Corporation</td>
<td>Rocco Russo</td>
<td>Blank Children’s Hospital</td>
</tr>
<tr>
<td>Lisa James</td>
<td>University of Iowa Student Health Center</td>
<td>Vickie Smith</td>
<td>Linn County Health Department</td>
</tr>
<tr>
<td>Sandy Jirsa</td>
<td>University Hygienic Laboratory</td>
<td>Brenda Sperry</td>
<td>University of Iowa Student Health Center</td>
</tr>
<tr>
<td>Lori Kramer</td>
<td>Medical Associates Health Plan</td>
<td>Gina Spinler</td>
<td>Iowa Department of Public Health</td>
</tr>
<tr>
<td>Betty Krones</td>
<td>Cerro Gordo County Health Department</td>
<td>Rachel Stolz</td>
<td>Council Bluffs City Health Department</td>
</tr>
<tr>
<td>Tracy Kueter</td>
<td>Sioux Valley Health Plan</td>
<td>Roma Taylor</td>
<td>Scott County Health Department</td>
</tr>
<tr>
<td>Ann Laros</td>
<td>University of Iowa Student Health Center</td>
<td>Dennis Troy</td>
<td>Becton-Dickinson and Company</td>
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<tr>
<td>Joe Lerberg</td>
<td>Iowa Department of Human Services</td>
<td>Kristin VanGilder</td>
<td>Coventry Health Care of Iowa</td>
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<tr>
<td>Jodie Liebe</td>
<td>Iowa Department of Public Health</td>
<td>Dan Weakly</td>
<td>Siouxland District Health Department</td>
</tr>
<tr>
<td>Heather Marthers</td>
<td>Women’s Health of Washington</td>
<td>Shannon Wood</td>
<td>Iowa Department of Public Health</td>
</tr>
<tr>
<td>Mary McCann</td>
<td>Polk County Health Department</td>
<td>Judy Yu</td>
<td>Abbott Molecular Incorporated</td>
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**Special Acknowledgements:**

The Primary Contributors are pleased to recognize Elizabeth Raasch, STD Program Spring 2008 Intern, without whom, this project would not have been possible.
The Goal of this toolkit is to increase health care providers’ knowledge and skills to prevent and screen for Chlamydia and other related infections in adolescents and young adults in an office-based setting.

CME Objectives:
After reviewing and completing the educational activity, participants should be able to:

- Identify the signs and symptoms of Chlamydia infection
- Provide care for Chlamydia infection in accordance with current testing and treatment guidelines
- Recognize trends and current epidemiology of Chlamydia in Iowa
- Understand the current factors and characteristics of Chlamydia infection and partner management in Iowa
- Comply with the legal requirements for practitioners for testing, treatment, and reporting Chlamydia, other STDs, and HIV/AIDS in Iowa
- Appreciate the issues of Gonorrhea co-morbidity

Accreditation Statement:
This activity has been planned and implemented in accordance with the Essentials Areas and Policies of the Missouri State Medical Association through the joint sponsorship of the St. Louis STD/HIV Prevention Training Center at Washington University in Saint Louis, Missouri, Development Systems, Incorporated, and the Iowa Department of Public Health. The Saint Louis STD/HIV Prevention Training Center is accredited by the Missouri State Medical Association to provide continuing education for physicians.

Designation Statement:
The Saint Louis STD/HIV Prevention Training Center designates this educational activity for a maximum of 2.0 AMA PRA™ Category 1 credit. Physicians should only claim credit commensurate with their participation in the activity.

- The estimated time to complete this educational activity is: Two Hours
- Expiration Date for no-cost CME’s for this activity: September, 2009
- This toolkit was last reviewed on August 22, 2008. The next review will occur in August, 2009.

Instructions for Obtaining CME Credit:

- Read all of the educational materials included in this toolkit
- Complete the Post-Intervention Questionnaire using the answer sheet provided.
- Complete the evaluation questions at the bottom of the Post-Intervention Questionnaire sheet provided.
- Send the Post-Intervention Questionnaires to:

  Deloris Rother, MPH, Manager
  Prevention Training Center
  St. Louis STD/HIV Prevention Training Center
  Washington University School of Medicine
  660 S. Euclid Avenue, Campus Box 8051
  St. Louis, MO  63110-1093
  Telephone: (314) 747-0294
  FAX: (314) 362-1872
  Std/hiv@im.wustl.edu

- A certificate of credit will be mailed to you.
- Retain a copy of your certificate for your records.

For any questions or comments concerning this toolkit, please contact:
The Iowa Department of Public Health STD Program
www.idph.state.ia.us/adper/std_control.asp
515-281-4936 or 515-281-3031
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Web site Links

Saint Louis STD/HIV Prevention Training Center Std/hiv@im.wustl.edu
Iowa Dept of Public Health: STD Program www.idph.state.ia.us/adper/std_control.asp
Centers for Disease Control and Prevention (CDC) www.cdc.gov/std
American Social Health Association (ASHA) www.ashastd.org
National Committee for Quality Assurance (NCQA) www.ncqu.org
Iowa General Assembly www.legis.state.ia.us
Iowa Department of Human Services www.dhs.state.ia.us
Youth Law Center www.ylc.org
National Center for Youth Law www.youthlaw.org
Youth Risk Behavior Surveillance System www.cdc.gov/HealthyYouth/yrbs/index.htm
Behavioral Risk Factor Surveillance System www.cdc.gov/brfss
CDC Treatment Guidelines www.cdc.gov/std/treatment
Urban Dictionary www.urbandictionary.com
University Hygienic Laboratory www.uhl.uiowa.edu
Chlamydia Screening Criteria
Chlamydia Screening Criteria

The following section will take you through:

- The problem with Chlamydia and the Epidemiology of Chlamydia in Iowa
- The signs and symptoms of Chlamydia and a likely co-infection, Gonorrhea
- The screening criteria for Chlamydia
- Chlamydia Screening Maps
WHAT?

Chlamydia, caused by the bacteria *Chlamydia trachomatis*, is the most common bacterial sexually transmitted disease in the United States. It is estimated that there are 3 to 5 million cases of Chlamydia infection that occur each year. However, many of these cases are left undetected and untreated since up to 75% of women and 50% of men are asymptomatic.

Untreated and undetected Chlamydia can lead to:
- Pelvic Inflammatory Disease (PID), ectopic pregnancy, and infertility in women
- Urethritis in women and men
- Epididymitis in men
- Increased risk of acquiring and/or spreading HIV infection (*Individuals are 2 to 5 times more likely to become infected with HIV if exposed when infected with an STD*)
- Passing the infection to a newborn at birth if the mother is infected causing conjunctivitis and pneumonia in the child

WHO?

In the last ten years, there has been a 67% increase in Chlamydia cases in Iowa. Chlamydia is most commonly found among sexually active individuals ages 15-25. Other risk factors include:
- Unprotected sex
- Incorrect or lack of condom use
- New sex partner or multiple sex partners
- Past history of STDs

HOW?

Screening all sexually active women between the ages of 15 and 25 for Chlamydia is recommended by the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force and is included as a HEDIS (Health Care Effectiveness Data and Information Set) performance measurement expectation. When possible, screening should be performed among all sexually active men and women. Screening is an effective and cost-saving approach because it stops the infection from spreading and reduces the risk of Chlamydia’s serious complications, such as infertility.
What is HEDIS?

HEDIS is a set of performance measures that are voluntarily reported by health plans and used by the National Committee for Quality Assurance (NCQA) to measure the quality of care and level of service in health plans. The HEDIS Chlamydia Screening Measure estimates the proportion of sexually active females ages 15 to 24 who had at least one test for Chlamydia during the previous year as a plan member of Medicaid or a commercial health plan. Since the measure was introduced in 2000, reports have shown a persistently low proportion of eligible females who were Chlamydia-tested, and it is substantially lower compared to other reports of preventive and therapeutic services measured by HEDIS. However, increases in screening have been seen in women who receive care from providers participating in accredited health plans.
In the last 10 years, the number of reported Chlamydia infections in Iowa has increased over 67% to a record high of 8,643 cases. The Centers for Disease Control and Prevention (CDC) estimates that about 40% of Chlamydia infections remain undiagnosed and untreated each year. This means that in 2007, over 3,400 infections went undiagnosed and untreated in Iowa. Many of these cases are due to partners not being aware of exposure and/or being unable to seek testing and treatment. In fact, more than 11% of reported Chlamydia and Gonorrhea infections were repeat infections due to lack of partner treatment and over 17% of persons known to be exposed to STDs were unable to seek testing and treatment. In 2007, more than 37% of Iowans reported to have Chlamydia infection were co-infected with Gonorrhea. Chlamydia (CT) is most prevalent in young persons aged 15-24 years old which make up 74% of reported infections. Chlamydia is also disproportionate in Blacks and Hispanics who, together, make up 26% or reported infections while only accounting for 8% of Iowa’s population.

For more information on the prevalence of STDs in Iowa, please visit: 
http://www.idph.state.ia.us/adper/std_control.asp
Signs and Symptoms of Chlamydia

Most people have no symptoms of Chlamydia until complications such as pelvic inflammatory disease, ectopic pregnancy, infertility, urethritis or acute epididymitis arise. If signs and symptoms of Chlamydia are present, they usually begin 7 to 21 days after exposure and include the following:

Symptoms for Women:
- Many women have no symptoms
- Abnormal vaginal bleeding, discharge, or itching
- Burning or pain during urination
- More pain than usual during periods
- Cramps and pain in lower abdomen
- Anal discomfort, itching, or discharge

Symptoms for Men:
- Many men have no symptoms
- Watery or thin white discharge from penis
- Burning or pain during urination or bowel movement
- Anal discomfort, itching, or discharge

Signs and Symptoms of Gonorrhea

In 2007, 37% of Iowans reported to have Chlamydia infection were co-infected with Gonorrhea. Public health systems in Iowa provide dual testing for Chlamydia and Gonorrhea. While this toolkit is mainly specific for Chlamydia, most of the information may also be applied to testing and treatment of Gonorrhea as well. Most people have no symptoms of Gonorrhea until complications such as pelvic inflammatory disease, ectopic pregnancy, infertility, infection in joints, lesions on the skin, or acute epididymitis arise. If signs and symptoms of Gonorrhea are present, they usually begin 2 to 7 days after exposure and include the following:

Symptoms for Women:
- Many women have no symptoms
- Abnormal vaginal bleeding, discharge or itching
- Burning or pain during urination or bowel movement
- More pain than usual during periods
- Cramps and pain in lower abdomen
- Anal discomfort, itching or discharge

Symptoms for Men:
- Many men have no symptoms
- Thick, white or yellow discharge (pus) from penis
- Burning or pain during urination or bowel movement
- Anal discomfort, itching or discharge
Screening in Iowa

For asymptomatic, non-pregnant females: Routine annual testing for sexually active individuals ages 15-25. If a positive case is found, the patient should be treated and retested approximately 3-4 months after treatment. The patient should continue screening annually until they are age 25 or have a decreased risk of infection.

For uncomplicated symptomatic non-pregnant females and males: Conduct testing if signs/symptoms (as listed above) are indicative of Chlamydia. If positive, the patient should be treated and retested approximately 3-4 months after treatment. Providers also are strongly encouraged to retest all patients treated for Chlamydia infection whenever they next seek medical care within the following 3–12 months, regardless of whether the patient believes that his or her sex partners were treated.

For pregnant females: Conduct testing at first prenatal visit and rescreen if positive 3 weeks after completion of therapy to ensure therapeutic cure, considering the sequelae that might occur in the mother and neonate if the infection persists.
Chlamydia Screening Map for Asymptomatic Non-Pregnant Females

Take a Medical / Sexual History

Sexually Active?

Yes

Conduct Chlamydia laboratory testing and patient counseling

No

Patient Counseling Repeat sexual/medical history annually

Sexually Active?

Yes

Conduct Chlamydia laboratory testing and patient counseling

No

Patient Counseling Repeat sexual/medical history annually

Test Result

Negative

Repeat sexual/ medical history annually

Positive

Conduct genital/pelvic exam Test for Gonorrhea, Syphilis, HIV

Patient Counseling Recommend treatment regimen ¹ ² ³

Rescreening Recommended ⁴

Partner Management Report to local health jurisdiction

¹ Azithromycin dose: 1 gram p.o., single dose
² Doxycycline dose: 100 mg p.o. BID for 7 days
³ Alternative treatment regimen: Erythromycin base 500 mg p.o. QID for 7 days or Erythromycin ethylsuccinate 800 mg p.o. QID for 7 days or Ofloxacin 300 mg p.o. BID for 7 days or Levofloxacin 500 mg p.o. QD for 7 days
⁴ Because Chlamydia reinfection is common, it is recommended that rescreening of infected females be performed 3-4 months after treatment
Patient presents with symptoms 1

Conduct medical/sexual history
Conduct genital/pelvic exam
Stat labs as indicated (e.g. wet mount, gram stain, UA)

Yes

Specific findings indicative of Chlamydia 2

Chlamydia Laboratory Testing

Test Result

Positive

Conduct genital/pelvic exam
Test for Gonorrhea, Syphilis, HIV
Patient Counseling
Recommend treatment regimen 4,5,6
Rescreening Recommended 7

No

Yes

Other findings indicative of Chlamydia 3 or female 25 or under

Repeat sexual/medical history annually

No

Conduct Chlamydia laboratory testing annually through age 25

May 2008

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1 Symptoms: Females- abnormal vaginal discharge, abnormal vaginal bleeding or dysuria; Males- urethral discharge or dysuria
2 Females: mucopurulent cervicitis or cervical friability; Males- urethral discharge or evidence of urethritis by gram stain or UA
3 Females: abnormal vaginal discharge of unknown etiology; abnormal vaginal bleeding of unknown etiology or dysuria without evidence of urinary tract infection
4 Azithromycin dose: 1 gram p.o., single dose
5 Doxycycline dose: 100 mg p.o. BID for 7 days
6 Alternative treatment regimen: Erythromycin base 500 mg p.o. QID for 7 days or Erythromycin ethylsuccinate 800 mg p.o. QID for 7 days or Ofloxacin 300 mg p.o. BID for 7 days or Levofloxacin 500 mg p.o. QD for 7 days
7 Because Chlamydia reinfection is common, it is recommended that rescreening of infected females be performed 3-4 months after treatment
Chlamydia Screening Map for Pregnant Females

May 2008

1 Azithromycin dose: 1 gram p.o., single dose
2 Amoxicillin dose: 500 mg p.o. TID for 7 days
3 Alternative treatment regimen: Erythromycin base 500 mg p.o. QID for 7 days or Erythromycin base 250 mg p.o. QID for 14 days or Erythromycin ethylsuccinate 800 mg p.o. QID for 7 days or Erythromycin ethylsuccinate 400 mg p.o. QID for 14 days
4 Because Chlamydia reinfection is common and there is a risk of transmitting Chlamydia to a newborn infant, it is recommended that rescreening of infected females be performed 3 weeks after treatment or during the third trimester if the mother is at an increased risk of infection (under 25 years, new or multiple partners, etc)
Screening Tests for Chlamydia
Screening Test for Chlamydia

The following section will take you through:

- The recommended diagnostic tests for Chlamydia
- The advantages and disadvantages of each test type
Diagnostic Testing of Chlamydia

There are many different screening tests for Chlamydia:
- Culture
- DNA probe
- Direct Fluorescent Antibody (DFA)
- Enzyme Immunoassay (EIA)
- Nucleic Acid Amplified Test (NAAT)

Nucleic Acid Amplified Tests (NAAT) are recommended for Chlamydia testing because they are highly sensitive and specific. They also permit urine as a specimen, therefore avoiding a clinical pelvic exam. However, if a pelvic exam is scheduled, indicated or part of a routine exam, an endocervical NAAT is recommended. When performing a NAAT urine-based test, the patient should not have urinated for one hour prior to collection. If a patient shows signs or symptoms of infection, a urine based test should not be used and a swab test should be used instead. Generally, NAAT tests can check for both Chlamydia and Gonorrhea at the same time.

NAAT testing is not FDA approved for rectal or pharyngeal specimens.

The chart on the next page provides information about the current test technologies available for Chlamydia.
### Which test is right for your clinic?

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<th>Enzyme Immunoassay (EIA)</th>
<th>Nucleic Acid Probe (DNA Probe)</th>
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<tr>
<td>Sensitivity</td>
<td>95-98%</td>
<td>40-70%</td>
<td>65-75%</td>
<td>60-70%</td>
<td>60-75%</td>
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<tr>
<td>Specificity</td>
<td>&gt;99%</td>
<td>&gt;99%</td>
<td>97-99%</td>
<td>95-99%</td>
<td>97-99%</td>
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<tr>
<td><strong>Test Advantages</strong></td>
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<td></td>
<td>• Non-invasive urine specimens in addition to genital swabs.</td>
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<td>• Recommended test for medico-legal purposes</td>
<td>• Internally controlled for specimen adequacy</td>
<td>• Less expensive than NAATs</td>
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<td></td>
<td><strong>Most sensitive</strong></td>
<td></td>
<td>• Many types of specimens (endocervical, urethral, rectal, ocular, etc.)</td>
<td>• No refrigeration during transport required</td>
<td>• Rapid turn around time in lab</td>
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<tr>
<td></td>
<td>• Dual testing for Chlamydia and Gonorrhea available</td>
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<td></td>
<td>• No refrigeration during transport required</td>
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<td>• Rapid turn around time in lab</td>
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<td>• Effective for large scale screening</td>
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<td></td>
<td>• No refrigeration during transport required</td>
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<td>• Effective for large scale screening</td>
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<td><strong>Test Disadvantages</strong></td>
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<tr>
<td></td>
<td>• More expensive</td>
<td>• Less sensitive than NAATs</td>
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<td></td>
<td>• Needs high degree of technical skill</td>
<td>• Longer turn around time (2-3 days)</td>
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<td>• Only tests for Chlamydia</td>
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<td></td>
<td>• May require special facilities or clean areas</td>
<td>• Technically difficult (storage, transport, temperature)</td>
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<td>• Supplemental testing recommended</td>
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<tr>
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<td>• Comparatively expensive</td>
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<tr>
<td></td>
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<td>• Only tests for Chlamydia</td>
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Table Contents Provided by Rick Steece, PhD, D(ABMM), National Chlamydia Laboratory Coordinator, Centers for Disease Control and Prevention, May 2008.

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Iowa Law and Confidentiality Issues

The following section will take you through:

- Iowa Code specific to the control of STDs
- The HIPAA Privacy Rule in Iowa
- Adolescents and the Iowa Code
- Overview of Sexual Abuse Code
- Creating a Youth Friendly and Confidentiality Conscious environment
Iowa Code for Control of STDs

Iowa Code chapter 139A: Communicable and Infectious Diseases and Poisonings is the section of Iowa Code that contains language specific to STD reporting and practices. Some frequently referenced sections are highlighted here. The full code can be viewed at: http://www.legis.state.ia.us by typing 139A into the “Quick Find” search engine titled “Bills and Iowa Code”.

Section 139A.30 Confidential Reports
“Reports to the department which include the identity of persons infected with a sexually transmitted disease or infection, and all such related information, records, and reports concerning the person, shall be confidential and shall not be accessible to the public. However, such reports, information, and records shall be confidential only to the extent necessary to prevent identification of persons named in such reports, information, and records; the other parts of such reports, information, and records shall be public records. The preceding sentence shall prevail over any inconsistent provision of this subchapter.”

Section 139A.31 Report to Department
“Immediately after the first examination or treatment of any person infected with any sexually transmitted disease or infection, the health care provider who performed the examination or treatment shall transmit to the department a report stating the name of the infected person, the address of the infected person, the infected person’s date of birth, the sex of the infected person, the race and ethnicity of the infected person, the infected person’s marital status, the infected person’s telephone number, if the infected person is female, whether the infected person is pregnant, the name and address of the laboratory that performed the test, the date the test was found to be positive and the collection date, and the name of the health care provider who performed the test. However, when a case occurs within the jurisdiction of a local health department, the report shall be made directly to the local health department which shall immediately forward the information to the department. Reports shall be made in accordance with rules adopted by the department. Any person filing a report of a sexually transmitted disease or infection who is acting reasonably and in good faith is immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of such report. “

Section 139A.32 Examination results from laboratory- report.
“A person in charge of a public, private, or hospital clinical laboratory shall report to the department, on forms prescribed by the department, results obtained in the examination of all specimens which yield evidence of or are reactive for those diseases defined as sexually transmitted diseases or infections, and listed in the Iowa administrative code. The report shall state the name of the infected person from whom the specimen was obtained, the address of the infected person, the infected person’s date of birth, the sex of the infected person, the race and ethnicity of the infected person, the infected person’s marital status, the infected person’s telephone number, if the infected person is female, whether the infected person is pregnant, the name and address of the laboratory that performed the test, the laboratory results, the test employed, the date the test was found to be positive and the collection date, the name of the health care provider who performed the test, and the name and address of the person submitting the specimen.”
Section 139A.35 Minors
“A minor shall have the legal capacity to act and give consent to provision of medical care or services to the minor for the prevention*, diagnosis, or treatment of a sexually transmitted disease or infection by a hospital, clinic, or health care provider. Such medical care or services shall be provided by or under the supervision of a physician licensed to practice medicine and surgery, osteopathy, or osteopathic medicine and surgery, a physician assistant, or an advanced registered nurse practitioner. Consent shall not be subject to later disaffirmance by reason of such minority. The consent of another person, including but not limited to the consent of a spouse, parent, custodian, or guardian, shall not be necessary.”

*The word “prevention” was added to this section in 2007 to allow for minors seeking STD-related immunizations such as an HPV or Hepatitis vaccine.

Section 139A.25 Penalties
“1. Unless otherwise provided in this chapter, a person who knowingly violates any provision of this chapter, or the rules of the department or a local board, or any lawful order, written or oral, of the department or board, or of their officers or authorized agents, is guilty of a simply misdemeanor.

2. Notwithstanding subsection 1, an individual who repeatedly fails to file any mandatory report specified in this chapter is subject to a report being made to the licensing board governing the professional activities of the individual. The department shall notify the individual each time that the department determines that the individual has failed to file a required report. The department shall inform the individual in the notification that the individual may provide information to the department or explain or dispute the failure to report.

3. Notwithstanding subsection 1, a public, private, or hospital clinical laboratory that repeatedly fails to file a mandatory report specified in this chapter is subject to a civil penalty of not more than one thousand dollars per occurrence. The department shall not impose the penalty under this subsection without prior notice and opportunity for hearing.”

Section 139A.41 Chlamydia and Gonorrhea*
“Notwithstanding any other provision of law, a physician, physician assistant, or advanced registered nurse practitioner who diagnoses a sexually transmitted Chlamydia or Gonorrhea infection in an individual patient may prescribe, dispense, furnish, or otherwise provide prescription oral antibiotic drugs to that patient’s sexual partner or partners without examination of that patient’s partner or partners. If the infected individual patient is unwilling or unable to deliver the medication to a sexual partner or partners, a physician, physician assistant, or advanced registered nurse practitioner may dispense, furnish, or otherwise provide the prescription oral antibiotic drug to the department or local disease prevention investigation staff for delivery to the partner or partners.”

*As of this writing, the section above is not yet included in the online version of the Iowa Code. To view this language, use the same website: http://www.legis.state.ia.us and type SF2177 in the “Quick Find” search engine titled “Bills and Iowa Code”.
HIPAA

This memo was originally released in 2003 with the inception of HIPAA to guide providers in understanding confidential reporting of infectious diseases. It was updated with current information in August, 2008.

TO: Iowa Health Care Providers and Clinical Laboratories
FROM: Heather L. Adams, Assistant Attorney General
RE: HIPAA PRIVACY RULES AND IOWA REPORTING REGULATIONS

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires covered entities to obtain consent or authorization from an individual for certain uses and disclosures of identifiable health information. The rule also provides that for certain uses and disclosures consent or authorization is not required.

The Privacy Rule expressly permits covered entities to report disease, injury, health conditions, and poisonings to public health authorities without obtaining consent or authorization from the patient. First, although the requirements of HIPAA generally preempt state law, HIPAA provides for certain exceptions to this general preemption rule. One such exception applies when state statute and state administrative rules provide for the reporting of disease or injury, ...or for the conduct of public health surveillance, investigation, or intervention. 45 CFR 160.203. Iowa Code chapters 135 and 139A and 641 Iowa Administrative Code chapter 1 require health care providers and laboratories to report all cases of reportable diseases (including all diseases and conditions, syndromes, occupationally related conditions, agriculturally related injuries, and poisonings listed in 641 IAC chapter 1) to the Iowa Department of Public Health (IDPH). Health care providers and laboratories are also required by law to cooperate and assist with disease investigations conducted by the IDPH or by a local public health board or department. 641 IAC 1.4(3). These provisions of law are not preempted by HIPAA and therefore the reporting of this information does not require prior consent or authorization.

HIPAA also provides for a number of permitted disclosures, i.e. those disclosures of protected health information for which consent or authorization is not required. HIPAA authorizes such disclosures to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. 45 CFR 164.512(a). HIPAA further authorizes disclosures for public health activities to a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions.[.] 45 CFR 164.512(b)(1)(i). As discussed above, health care providers and laboratories are required by Iowa law to report certain diseases and conditions, syndromes, occupationally related conditions, agriculturally related injuries, and poisonings to the IDPH. Hence, HIPAA does not require that covered entities obtain consent or authorization prior to releasing reportable disease information to IDPH.

In short, HIPAA provides no legal basis for health care providers or laboratories to refuse to notify IDPH or local health departments of reportable conditions, nor does HIPAA provide a legal basis for health care providers or laboratories to stop cooperating with IDPH or local health departments in the course of disease investigations, follow-up, or surveillance. Disclosures of reportable disease information are legally required and must continue to occur as mandated by state law.
Adolescents and the Iowa Code

According to Iowa Code section 599.1, a minor (an individual younger than 18 years of age) may seek medical care for the following without the permission or knowledge of his/her parents:

- Substance Abuse Treatment (Section 125.33);
- STD prevention, testing, and treatment (Section 139A.35);
- HIV testing – though if positive, Iowa law requires parent notification (Section 141A.7);
- Contraceptive care and counseling, including emergency contraception; and
- Blood donation if 17 years of age or older (Section 599.6).

A minor may also consent for evaluation and treatment in a medical emergency or following a sexual assault. However, treatment information cannot be kept confidential from parents.

Even though teenagers and young adults can receive these treatments without their parent’s knowledge, it is important to remember parents are a key part of all aspects of a teen’s life. Parents and teens should be encouraged to be open and honest with each other when it comes to healthcare decisions.

According to Iowa Code section 252.16, an emancipated minor is one who is married (or was ever married) or is one who:

- Is absent from the parental home with parent consent;
- Is self-supporting, receiving no financial income from parents;
- AND, an inconsistent relationship with being a part of the family of the parent exists.

Primary care providers play a key role in adolescent and reproductive health as part of preventive care and health care maintenance. Every state explicitly allows minors to consent for their own health services for STDs. No state requires parental consent for STD care or requires that providers notify parents that a minor has received STD services, except in limited or unusual circumstances.

The only time the confidentiality for minors can be breached is in the case of:

- Suicide threats
- Threat to harm others
- Positive HIV test (a consent form for minors is offered on the following page)
- Medical Emergency or sexual assault

Make certain minors know your office billing procedures. If a parent will receive a bill, the minor should be informed of that policy at the time of testing.

Adolescents also have the right to:

- Opportunities to learn about the cost of medical care, and to ask if they can get care that costs less or is free
- Opportunities to pay for certain services, like STD testing, out of pocket to prevent a mailed bill for services from breaching confidentiality
- Complete information, in words they can understand, about medical care
- Access to information contained on their medical record
Minor’s Consent for HIV Testing

I have been advised and understand the nature of the HIV antibody test and what the results would mean.

I understand that:

• HIV is the virus that causes AIDS
• The only way to know if I have HIV is to be tested
• State law protects the confidentiality of test results
• My health care provider will talk with me about notifying my parents and my sex and/or needle-sharing partners of possible exposure, if I test positive.

I hereby authorize the _________________________to perform this test.

I have been advised and understand that if my HIV test is positive, this agency is required to notify my parent or legal guardian of the positive result.

____________________ ___________________ ____________
Name of person testing (print) Signature Date

____________________ ___________________ ____________
Witness (print) Signature Date
Overview of Sexual Abuse Code

The following information is from Iowa Code Chapter 709 Sexual Abuse and Section 726.2 Incest. The full code can be viewed at http://www.legis.state.ia.us by typing the code number into the “Quick Find” search engine titled “Bills and Iowa Code”.

Definitions

- According to Section 702.5 Child, unless another age is specified, a “child” is any person under the age of fourteen years”.
- Sexual acts are deemed “abusive” in the following circumstances:
  - by force or against the will of the other
  - when consent is gained by threats of violence
  - when one is suffering from mental defect or incapacity
  - when one is a child (under the age of fourteen)
  - when one is a minor and the assailant is five or more years older

Penalties

1st Degree Sexual Abuse (Section 709.2) Class “A” Felony
1. Serious injury occurred: a disabling mental illness or bodily injury with substantial risk of death or permanent disfigurement.

2nd Degree Sexual Abuse (Section 709.3) Class “B” Felony
1. Display of a deadly weapon.
2. Threats to seriously injure or cause risk of death.
3. The victim is under the age of 12.
4. When aided or abetted by one or more persons.

3rd Degree Sexual Abuse (Section 709.4) Class “C” Felony
1. Any sex act that is done by force or against the will of the other.
2. The victim suffers from mental defect or incapacity which precludes giving consent.
3. The victim is under the age of 14.
4. The victim is 14 or 15 and the perpetrator is a member of the same household, or related by blood to the 4th degree, or is four or more years older than the victim.
5. The perpetrator is in a position of authority over the victim and used this authority to coerce the victim: employer, teacher, therapist, minister, etc.

Lascivious Acts with a Child (Section 709.8) Class “C” to “D” Felony
Any of the following acts committed by a person that is 16 years of age or older without the child’s consent for the purpose of arousing or satisfying the sexual desires of either of them:

- Fondle or touch the genitals of the child.
- Permit or cause a child to fondle or touch the person’s genitals or pubes.
- Solicit a child to engage in a sex act or solicit a person to arrange a sex act with a child.
- Inflict pain or discomfort upon a child or permit a child to inflict pain or discomfort on the person.
Attempted Sexual Abuse (Section 709.11)
A committed assault with the intent to commit sexual abuse is penalized as follows:
   a. Class “C” Felony if the result is a serious injury.
   b. Class “D” Felony if the result is any bodily injury other than a serious injury.
   c. Aggravated Misdemeanor if no injury results.

Lascivious Conduct with a Minor (Section 709.14) Serious Misdemeanor
It is unlawful for a person over 18 years of age who is in a position of authority over a minor to
force, persuade, or coerce a minor with or without consent to disrobe or partially disrobe for the
purpose of arousing or satisfying the sexual desires of either of them.

Incest (Section 726.2) Class “D” Felony
A person, except a child as defined in section 702.5 (under the age of 14), who performs a sex
act with another whom the person knows to be related to the person, either legitimately or
illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt,
uncle, niece, or nephew, commits incest.

When and How to place a Mandatory Report...

Always seek counsel from your office’s legal representative or a county attorney when there are
questions or concerns regarding legal issues. The following resources offer guidance regarding
Mandatory Reporting and Child Abuse:

Iowa’s Child and Dependent Adult Abuse Hotline:
1-800-362-2178

Iowa Department of Human Services Guide for Mandatory Reporters website PDF:

Iowa Department of Human Services website:
http://www.dhs.state.ia.us

Iowa Department of Elder Affairs Dependent Adult Abuse website:
http://www.state.ia.us/elderaffairs/advocacy/elderabuse.html

Youth Law Center website:
http://www.ylc.org

National Center for Youth Law website:
http://www.youthlaw.org
Creating a “TEEN FRIENDLY and CONFIDENTIALITY CONSCIOUS” Environment…

Many adolescents have concerns related to testing for STDs which can prevent them from seeking information and care. Studies suggest that the reasons for not obtaining care include:

- Access barriers such as no insurance and no transportation
- Concern with privacy and confidentiality
- Inexperience as healthcare consumers
- A belief that the problem would go away
- Fear about discovering that they have an STD
- Fear of HIV/AIDS
- A belief that it is possible to die from a Chlamydial infection

Creating a teen friendly and confidentiality conscious office:

- Offer an atmosphere that is appealing to adolescents (pictures, posters, wallpapers, music and magazines that interest adolescents and reflect their cultures and literacy levels).
- Include décor that reflects the genders, sexual orientations, cultures and ethnicities of your patients. For example, display a rainbow poster that is gay, bisexual, lesbian, and transgender (GBLT) sensitive.
- Make sure that messages can be left on the patient’s contact phone number before doing so.
- Always shut the door when discussing anything sensitive, such as sexual history, weight, or substance use.
- Offer after-school hours.
- Describe what procedures you are performing step-by-step and include why each step is necessary.
- Make sure that all information in the form of brochures, pamphlets, etc. is small enough to fit into a purse or wallet.
- Make sure that brochures, pamphlets, etc. can be obtained in private rather than in the waiting room where others will be able to see the information is being gathered.
- Make it clear at the beginning of the appointment that you are required to maintain patient confidentiality, except under very specific circumstances.
- Post an office policy about confidential issues pertaining to youth and their families in public areas.
- Train and educate staff members regarding laws that pertain to adolescents and their right to receive care without parent or guardian consent.
- Keep in mind that communication skills may not reflect the true cognitive and problem-solving abilities.
- Congratulate the patient when they are making healthy choices and decisions.

The following form can assist in making sure patients are contacted in the manner they wish to be contacted in.
Patient Contact Form

Patient Name________________________________ Birth Date ___________________
Address ________________________________________________

Please tell us about the best ways to reach you to talk about your medical care. Check everything that applies:

Today’s Date is ________________

By mail
☐ At the address above
☐ At this address

By phone (Make sure to give us the number)
☐ Home phone number ______________ Can we leave a message (circle):  YES  NO
☐ Cell phone number ______________ Can we leave a message (circle):  YES  NO
☐ Beeper number _________________ Can we leave a message (circle):  YES  NO
☐ School Clinic number ____________ Can we leave a message (circle):  YES  NO

May we identify ourselves when we call?
☐ Yes
☐ No

If no, who should we say has called so that you know to call us back? ______________

Does it matter whether a guy or girl office assistant makes the call?
☐ Yes, girl assistants only
☐ Yes, guy assistants only
☐ No, it doesn’t matter

What are the best times to reach you? ________________________________________

If we are unable to reach you according to the plan above, is there someone else we can call who will help us reach you?
☐ Yes (provide the name, relationship, and phone number on the line below)
____________________________________________________________________
☐ No

Is there anything else we should know that will help us give you the best care possible?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

If you need to reach us:
Your Doctor’s name is ________________________
Call ______________________ during office hours ______________
Call ________________________ on weekends or after regular office hours

Our office address is:
Billing and Coding

The following section will take you through:

- Ways to widely screen for Chlamydia infection
- Office Billing and the Explanation of Benefits (EOB)
- Billing and Coding to maintain Confidentiality
Screen as widely as possible

Routine Chlamydia screening for sexually active adolescent and young adult females is recommended by several national organizations including the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the U.S. Preventive Services Task Force. Routine screening for males is also important since males are often asymptomatic, and, if sexually active and infected, can unknowingly transmit an infection to a female.

Billing and coding for confidential services is a complex issue. A recent survey of Iowa providers showed that some providers are able to successfully screen or refer patients for screening.

Here’s How:

Consider “NORMALIZING” screenings for Chlamydia and other STDs if questions about billing come up. Screen during annual exams, sports physicals, and during other routine testing.

“We routinely screen teens to make sure we are not missing any problem that was not discussed or disclosed.”

OR:

Offer to allow the test to be paid for during that visit and out of pocket. Make sure the patient has the ability to pay for the test in a manner that will not breach confidentiality. This might mean making arrangements for the payments to occur in the exam room.

OR:

Become familiar with local low- or no-cost Family Planning and STD Clinic services.

Go to http://www.idph.state.ia.us/adper/std_control.asp for a PROVIDER DIRECTORY of the IDPH STD Program’s publicly funded screening sites. The directory is not included in this toolkit since the clinic information changes frequently.
Office Billing and the EOB:

It is important for minors to know that being covered by his or her parents’ medical insurance means he or she may need to consent to medical records being shared if they want the insurance to cover testing and treatment. This is a good time to coach a minor to openly communicate with parents about sexual health and behavior.

Most of the major health plans in Iowa were contributors in creating this toolkit. Different health plans in Iowa have differing policies about disclosure of the services on an EOB:

- Some will refer any questions to the provider.
- Some will disclose only to the primary holder of the insurance.
- Some will disclose to a parent if the service was for a member under the age of 18.

**ALL have one thing in common…**

The EOB **DOES NOT** state “Chlamydia Test” or any other specific language about the service provided. The language on the EOB is most likely to be something like “Medical Service” or “Laboratory Service”.

The bill from the provider is the documentation most likely to state the specific procedures performed. Check your office policies to be certain what your billing procedures are, and that you are prepared to answer questions regarding the specific services listed on patient bills.

The next page offers general ICD-9 codes from 2007 meant as a reference point to the area of the current ICD-9 manual where needed billing codes will be located.
Billing and Coding for Confidential Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Price</th>
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<tbody>
<tr>
<td>789.00</td>
<td>Abdominal Pain</td>
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<td>Abdominal Tenderness</td>
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<td>796.4</td>
<td>Abnormal Findings, w/o Diagnosis (Examination, Laboratory Test)</td>
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<tr>
<td>626.9</td>
<td>Abnormal Periods (Grossly)</td>
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<td>788.69</td>
<td>Abnormal Urination NEC</td>
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<td>995.50</td>
<td>Abuse Child/Adolescent</td>
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<td>995.54</td>
<td>Abuse Physical</td>
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<tr>
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<td>Amenorrhea/Primary, Secondary</td>
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<td>565.0</td>
<td>Anal Fissure, Tear</td>
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<td>280.1</td>
<td>Anemia, Iron Deficiency</td>
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<td>285.9</td>
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<td>616.10</td>
<td>Bacterial Vaginosis</td>
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<td>607.1</td>
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<td>616.2</td>
<td>Bartholin Gland, Cyst</td>
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<td>Bartholin’s Gland, Abscess</td>
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<td>680.9</td>
<td>Boil, Carbuncle</td>
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<td>Breast Asymmetry</td>
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<td>Breast Lump/Mass</td>
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<td>099.41</td>
<td>Chlamydia Urethritis (STD)</td>
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<td>078.11</td>
<td>Condyloma Acuminatum</td>
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<td>372.00</td>
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<td>Contact/Exposure to STD</td>
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<td>Contraception Surveillance</td>
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<td>Contraceptive Management NEC (Depo-Provera)</td>
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<td>Counseling, Parent-Child Conflict</td>
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<td>Rash</td>
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Scabies 133.0

Screen for:
Chlamydia & Viral Disease V73.88
Thyroid V77.0
Sebaceous Skin Cyst 706.2
Scrotal/Testicular Mass 608.89
Short Stature 783.43
Skin Infection, Unspecified 686.9
Somatization Disorder 300.81
Sport/Job/Camp Physical V70.3
STD, Contact V01.6
STD, Counseling V65.45
STD, Follow-up Exam V67.59
STD, Screening V75.9
STD, Unspecified 099.9
Stress, Acute 308.3
Syphilis, Genital (Primary) 091.0
Testicle Torsion 608.2
Throat Pain 784.1
Thyroid Enlargement 240.9
Tonsillitis, Acute 463
Trichomonal, Vulvovaginitis 131.01

Underweight 783.22
Urethral Discharge 788.7
Urethritis, Gonococcal 098.0
Urethritis, STD 099.40
Urethritis, Non-STD 598.8
Urinary Complaints, Sx 788.9
Urinary Frequency 788.41
Urinary Urgency 788.63
UTI 599.0

Vaginal Bleeding 623.8
Vaginal Discharge 623.5
Varicocele 456.4
Vertigo/Dizziness 780.4
Viral Exanthem 057.9
Viral Infection, Unspecified 079.99
Vomiting (Alone) 787.03
Vomiting, Persistent 536.2
Vulvovaginitis 616.10
Vulvovaginitis, Candidal 112.1
Vulvovaginitis, Trichomoniasis 131.01

Warts, Genital 078.19
Warts, Unspecified 078.10
Weight Gain/Overweight 783.1
Weight Check 783.3
Weight Loss 783.21
Well Child (0-17) V20.2
Well Child (18+) V70.0
Worried Well (Could Not Find Problem) V65.5
(See also V71.x)

The previous pages offer general ICD-9 codes from 2007 meant as reference points to the area of the current ICD-9 manual where needed billing codes will be located.
Taking A Sexual History
Taking a Sexual History

The following section will take you through:

- The important components of a Sexual History
- Examples for taking a Sexual History
- The Sexual History Questionnaire
The Importance of a Sexual History

Taking a sexual history is a necessary component of a patient’s exam. It provides important information to the provider in order to:

- identify if the patient is at risk for Chlamydia (or other STDs, including HIV)
- prevent or treat possible infection among the patient’s partner(s)
- educate the patient on reducing their risk
- to identify appropriate anatomical sites for certain STD tests

A sexual history needs to be taken during a patient’s initial visit, during routine preventive exams, and when you see signs of sexually transmitted diseases (STDs).

Introduction to a Sexual History

Some patients may not be open or comfortable with talking about their sexual behaviors, partners, practices, or history. By letting them know that a sexually history is an important part of a regular medical exam or physical history; you may be able to put the patient at ease. It is also important to inform the patient that their information is completely confidential and will not be shared with anyone but their health care provider. Your method for taking a sexual history will need to be modified in order to be appropriate for each patient based on their gender, age, and culture. Using open-ended questions will help guide the discussion.

Introduction Examples

- “I am going to ask you some questions about your sexual health and sexual practices. I understand that these questions are very personal, but they are important for your overall health and will not be shared outside of this room.”
- “I am going to ask you some questions that I ask to all of my patients. These questions are just as important as those concerning your physical or mental health. This information will be kept in complete confidence, just like the rest of our visits. Do you have any questions or concerns before we get started?”
- “Sexual health can impact the overall quality of life as greatly as the other areas of your health. Your sexual health can range from issues that are irritating to life threatening. I want to ask you some questions about your sexual history and practices so that we can make sure your sexual health is in check.”

**If your patient seems shy or unwilling to be open about their sexual history, refer to the questionnaire at the end of this section to help you get started.**
The 5 P’s of a Sexual History

I. Practices
This area is addressed to determine which types of sexual contact the patient is having or has had in the past year. By determining which sexual practices the patient participates in, you will be able to assess the patient’s risk as well as determine which testing is necessary and which anatomical sites specimens should be collected from. If risks are identified, strategies to reduce those risks should be developed with the patient. Other risks may include having sex while under the influence of alcohol or drugs, having unwanted sex, using IV drugs (HIV/Hepatitis screening), and the behaviors of the patient’s partner(s).

II. Partners
In this section it is important to discuss the number and gender of your patient’s partners while remembering not to make assumptions about sexual orientation. If the patient has only had one partner within the last year, determine the length of the relationship.

III. Protection from STDs
The purpose of this component is to assess the patient’s use of protection as well as what kind, how often it’s used, if it’s used correctly, and under what circumstances it’s used. It’s also important during this discussion to ask the patient if they have any questions about protection or need additional information about methods of protection.

IV. Past history of STDs
It is important to determine whether the patient has had a previous history of STDs because it may place them at a greater risk now. Ask the patient if they have ever been tested for Chlamydia or any other STDs. If the patient has been tested before and has had a previous STD diagnosis, find out when it was diagnosed and how they were treated. Also, ask if there have been any recurring symptoms or diagnoses. Remember to discuss the patient’s current or previous partner(s) and whether they have ever been diagnosed and treated for an STD. This will help assess any additional risk the patient might have.

V. Prevention of Pregnancy
Based on what information you’ve gathered thus far in the sexual history, you may be able to determine if the patient is at risk of becoming pregnant or fathering a child. Ask the patient if a pregnancy is currently desired between the patient and their partner. If it is not desired, ask if the patient is concerned about getting pregnant or getting a partner pregnant. Discuss with the patient their methods of contraception or birth control. Provide any needed information on contraceptive methods.

Completing the History
Thank the patient for being honest and open about their sexual history and praise them for any protective practices. For patients at risk of Chlamydia or other STDs, encourage them to get tested and explain prevention methods to reduce or avoid risk. Express your concern. It may help the patient accept any counseling referrals they are given.
The 6th P: Parent Involvement

A parent’s involvement in their child’s health is crucial to their child’s well-being. However, their involvement may change during every year of their child’s adolescent growth to adulthood. The following steps can help you as a provider to transition from parent accompaniment to a confidential setting for the adolescent while still encouraging the parent’s involvement and discussion with their child.

1.
- Send a letter to the adolescent patients’ parents on the youth’s 11th or 12th birthday explaining the policy to help families come prepared for the adolescent and provider to spend time alone. *An example is on the next page.*
- Explain the goals and plan for the visit
- Explain any policies regarding adolescent visits
- Validate the parental role in their child’s health and well-being
- Elicit any specific questions or concerns from the parent
- Direct questions and discussion to the adolescent while attending to and validating parental input

2.
- Invite the parent(s) to have a seat in the waiting area, assuring them that you will call them prior to closing the visit

3.
- Once the parent is out of the room, revisit issues of consent and confidentiality with the adolescent, including situations when confidentiality has to be breached (suicidality, abuse, positive HIV test, etc.)
- Revisit areas of parental concern with the adolescent and obtain the adolescent’s perspective
- Conduct the psycho-social interview and physical exam (ascertain whether the adolescent desires parent’s presence during the physical exam and accommodate the adolescent’s preference)

4.
- Clarify what information from the psycho-social interview and physical exam the adolescent is comfortable sharing with the parent
- Ask the patient if they need help sharing sexuality information with their parent: what type of help, what the adolescent expects the parent’s reactions to be, and how can you as a provider help that go smoothly
- Invite the parent back to close the visit with both parent and adolescent

Remember that even when the chief complaint is acne or an earache, there may be underlying issues which will only surface when the patient is directly asked.
Date

Dear Parent or Guardian,

Welcome to adolescent services with {your practice’s name}. Now that your son or daughter is a teenager, there are some things I would like to share with you that are important to providing the best medical care. Your child’s body is changing and so are his or her feelings. There are many health risks during the teenage years that we try to prevent, such as accidents, violence, unprotected sex, alcohol and drug use, and stress.

Some areas of teen health that we may talk about during appointments are:

- Diet, exercise, and body image
- Working/jobs
- Fighting, danger, and violence
- Depression and stress
- Sexuality and sexual behavior
- Peer pressure and school
- Safety and driving
- Dating and relationships
- Smoking, drugs, and alcohol
- Family life

It is good for parents to stay close to their children. It is also important for you to allow them some time alone to talk about their health and changes in their bodies and lives. This will help your teenager make good decisions. I encourage teenagers to share information about their health with their parents or guardians. However, there will be some things that your teenager would rather talk about with a doctor, nurse, or counselor. Iowa law allows teenagers to receive some health care services on their own. Health care providers have to keep those services confidential. “Confidential” means I will only share this information if a teenager says it is alright. I will also share this information if someone is in danger.

I ask that you support these rules and help your teen learn to care for their own health needs. I look forward to providing ongoing medical care for your child. I will be happy to talk to you about the questions or concerns you may have about this letter and your child’s health.

Sincerely,
Using the Questionnaire

The following questionnaire can be used by the provider as a guide, or given to the patient to take in order to find information regarding the patient’s sexual history. The questionnaire should be used as a “kick start” to taking the sexual history.

*The form does not cover all aspects of a sexual history for every patient. If the patient takes the questionnaire, it should then be discussed with the provider to go more in depth and give the patient the testing and care that they need.*

When working with adolescents it’s important to stay away from medical terms and try to use language similar to their literacy level. If you’re having problems understanding them or feel that your adolescent patients do not fully understand you, you can visit [www.urbandictionary.com](http://www.urbandictionary.com) to help you find slang or other words used for things such as sexual intercourse, partners, contraceptives, anus, vagina, penis, protection, condoms, etc.

Other Tools

If you would like to assess other possible risks of your patient’s health than just a sexual history, the following websites have some of these resources.

The Youth Risk Behavior Surveillance System (18 and under)
[http://www.cdc.gov/HealthyYouth/yrbs/index.htm](http://www.cdc.gov/HealthyYouth/yrbs/index.htm)

The Behavioral Risk Factor Surveillance System (Adults, over 18)
Sexual History Questionnaire

The following are questions about your sexual health. Your information will not be shared with anyone except your health care provider. Honest answers will help your provider to offer the best care possible and work with you to help you be healthy.

1. What kinds of sex have you had in the last 3 months?
   _____ Vaginal Sex (penis in vagina)  ___ Oral Sex (mouth on penis, vagina, anus)
   _____ Anal Sex (penis in the anus)    _____ I am not sexually active

2. Which kinds of sex have you had ever?
   _____ Vaginal Sex (penis in vagina)  ___ Oral Sex (mouth on penis, vagina, anus)
   _____ Anal Sex (penis in the anus)    _____ I have never been sexually active

3. In the last year, have you had more than one sex partner? (Sex partners are anyone you’ve had sex with – even if it was just once.)
   _____ Yes        _____ No, I’ve had one partner for the last year    _____ No, I haven’t had any partners

4. In the past 6 months, how many sex partners have you had?
   ______

5. Are your sex partners…?
   _____ Males only       _____ Both Males & Females
   _____ Females only    _____ No sex partners

   If you are sexually active or have been sexually active, please answer the following questions.

6. Do you and your sex partner(s) use condoms?
   _____ Yes            _____ No

7. How often do you and your sex partner(s) use condoms?
   _____ Always        _____ Sometimes        _____ Never

8. If sometimes, in what situations do you use condoms?
   ____________________________________________________________________

9. Have you ever been tested for STDs or HIV?
   _____ Yes      _____ No

10. Has any of your sex partners ever had an STD?
    _____ Yes      _____ No        _____ Don’t know

11. If yes, were you also tested for the same STD?
    _____ Yes      _____ No

12. Have you ever had a sexually transmitted disease (STD)?
    _____ Yes      _____ No        _____ Don’t know

   If yes, when?__________________________________________

13. Have you had any itching, burning, swelling, bumps, etc in or around your vagina, penis, mouth, anus in the past 6 months?
    _____ Yes      _____ No

14. Are you concerned about getting pregnant or getting your partner pregnant?
    _____ Yes      _____ No

15. List all of the forms of birth control (condoms, pills, IUD, the patch, etc.) you are using.
    ____________________________________________________________________
Use this chart to take notes when taking a patient’s sexual history.

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<tr>
<th></th>
<th>Vaginal Sex</th>
<th>Anal Sex</th>
<th>Oral Sex</th>
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<tbody>
<tr>
<td>Are you currently having…?</td>
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<td>Have you ever had…?</td>
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<td>When was the last time you had…?</td>
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<tr>
<td>How many sex partners have you had in the last 6 months?</td>
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<tr>
<td>How many sex partners do you currently have?</td>
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<tr>
<td>Do you have _____ sex with men?</td>
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<td>Do you have _____ sex with women?</td>
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<td>Do you have sex with both men and women?</td>
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<tr>
<td>Do you use condoms?</td>
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<tr>
<td>How often do you use condoms?</td>
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<td>When don’t you use condoms?</td>
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<tr>
<td>Have you had any burning, itching, bumps, swelling, belly aches, etc. recently?</td>
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<tr>
<th></th>
<th>Genitals</th>
<th>Anus</th>
<th>Mouth</th>
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<tr>
<td>Explanation (Yes/No, Specify)</td>
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<tr>
<td>Have you ever been tested for STDs?</td>
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<td>Have you ever had an STD?</td>
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<tr>
<td>Have any of your sex partners ever had an STD?</td>
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<tr>
<td>Are you concerned about getting pregnant or getting your partner pregnant?</td>
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<td>Are you using any birth control?</td>
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<tr>
<td>What kind of birth control are you using?</td>
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CDC Treatment Guidelines

The following section will take you through:

- CDC Treatment recommendations for Chlamydia
- CDC Treatment recommendations for Gonorrhea
- Presumptive Treatment criteria
Treating infected patients prevents transmission to sex partners and re-infection of the patient. In addition, treatment of Chlamydia in pregnant women usually prevents transmission of Chlamydia to infants during birth. CDC recommends the following treatment regimens for Chlamydia.

**Chlamydia Treatment**

***ALL Regimens, regardless of single dose or 7 day treatment, must be taken in addition to 7 days of Abstinence. If a partner is involved, then the patient must remain abstinent until 7 days after the partner’s treatment as well.***

- **Males and Non-pregnant Females**
  - Azithromycin 1g orally in a single dose
  - Doxycycline 100mg orally twice a day for 7 days

- **Alternatives for Males and Non-pregnant Females**
  - Erythromycin base 500mg orally four times a day for 7 days
  - Erythromycin ethylsuccinate 800mg orally four times a day for 7 days
  - Ofloxacin 300mg orally twice a day for 7 days
  - Levofloxacin 500mg orally for 7 days

- **Pregnant Females**
  - Azithromycin 1g orally in a single dose
  - Amoxicillin 500mg orally three times a day for 7 days

- **Alternatives for Pregnant Females**
  - Erythromycin base 500mg orally four times a day for 7-14 days
  - Erythromycin ethylsuccinate 800mg orally four times a day for 7 days
  - Erythromycin ethylsuccinate 400mg orally four times a day for 14 days

- **Children (< 45 kg): Urogenital, rectal**
  - Erythromycin base 50 mg/kg/day orally (4 divided doses) daily for 14 days
  - Ethylsuccinate 50 mg/kg/day orally (4 divided doses) daily for 14 days

- **Neonates: Ophthalmia neonatorum, pneumonia**
  - Erythromycin base 50 mg/kg/day orally (4 divided doses) daily for 14 days
  - Erythromycin 50 mg/kg/day orally (4 divided doses) daily for 14 days

Counsel patients to abstain during treatment, use barriers and contraception for prevention, and to re-test in 3 to 4 months.

For more information on treatment guidelines, please visit [www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment) or see the quick reference guide at the end of this section.
Gonorrhea Treatment

Patients infected with Gonorrhea frequently are co-infected with Chlamydia. This finding has led to the recommendation that patients treated for gonococcal infection also be treated routinely with a regimen that is effective against uncomplicated genital Chlamydia infection. Because of the high sensitivity of NAATs for Chlamydia infection, patients with a negative Chlamydia NAAT result at the time of treatment for Gonorrhea do not need to be treated for Chlamydia as well. However, if Chlamydia test results are not available or if a non-NAAT was negative for Chlamydia, patients should be treated for both Gonorrhea and Chlamydia.

***ALL Regimens, regardless of single dose or 7 day treatment, must be taken in addition to 7 days of Abstinence. If a partner is involved, then the patient must remain abstinent until 7 days after the partner’s treatment as well.

- **Uncomplicated Gonococcal Infections of the Cervix, Urethra, and Rectum**
  - Ceftriaxone 125mg IM in a single dose
  - Cefixime 400mg orally in a single dose
  - Treatment for Chlamydia if Chlamydia cannot be ruled out

- **Alternatives for Cervix, Urethra, and Rectum**
  - Single-dose cephalosporin regimens
  - Spectinomycin 2g in a single IM dose (not available in U.S.)
  - Treatment for Chlamydia if Chlamydia cannot be ruled out

- **Men who have sex with Men (MSM) or Heterosexuals with a History of Recent Travel**
  - Ceftriaxone 125mg IM in a single dose
  - Cefixime 400mg orally in a single dose
  - Treatment for Chlamydia if Chlamydia cannot be ruled out

- **Gonococcal Infection of the Pharynx**
  - Ceftriaxone 125mg IM in a single dose
  - Treatment for Chlamydia if Chlamydia cannot be ruled out

- **Conjunctiva**
  - Ceftriaxone 1g IM once plus lavage the infected eye with saline solution once
  - Treatment for Chlamydia if Chlamydia cannot be ruled out

- **Children ($\leq 45$ KG)**
  - Ceftriaxone 125mg IM once
  - Treatment for Chlamydia if Chlamydia cannot be ruled out

- **Pregnant Women**
  - Ceftriaxone 125mg IM once
  - Cefixime 400mg orally in a single dose
  - Treatment for Chlamydia if Chlamydia cannot be ruled out

Counsel patients to abstain from sex during treatment, use barriers and contraception as preventative measures and to re-test in 3 to 4 months.
Presumptive Treatment Criteria

Presumptive treatment occurs before test results are available when a patient presents one or more complaints. Treatment may occur without actually testing the client. The following are criteria for presumptive diagnosis and treatment of Chlamydia:

Males
- History of urethral discharge
- History and/or exam consistent with urethritis, epididymitis, or non-gonococcal urethritis
- History of sexual partner with Chlamydia infection
- History of sexual partner with gonococcal infection
- Symptomatic partner
- History of partner with mucopurulent cervicitis or PID
- Rape victim

Females
- Physical exam consistent with mucopurulent cervicitis, friable cervix, or positive whiff test
- Signs and symptoms of PID
- History of sexual partner with Chlamydia infection
- History of sexual partner with gonococcal infection
- Symptomatic partner
- History of partner with urethritis, epididymitis, or non-gonococcal urethritis
- Rape victim

For more information on treatment guidelines, please visit [www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment)

The next page contains a summary of the 2006 CDC STD Treatment Guidelines.
SUMMARY OF THE 2006 CDC SEXUALLY TRANSMITTED DISEASES (STD) TREATMENT GUIDELINES
ST. LOUIS STD/HIV PREVENTION TRAINING CENTER

These guidelines for the treatment of STDs reflect the recommendations of the 2006 CDC STD Treatment Guidelines. These are outlines for千古reference that focus on STDs encountered in an outpatient setting and are not an exhaustive list of effective treatments. Please refer to the complete document of the CDC for more information or call the STD Program. These guidelines are to be used for clinical guidance and are not to be construed as standards or inflexible rules. Clinical and epidemiological services are available through your State STD Program and staff is available to assist providers with confidential notification of sexual partners of patients infected with STDs and HIV.

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<tr>
<th>DISEASE</th>
<th>RECOMMENDED TREATMENT</th>
<th>ALTERNATIVES</th>
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<tr>
<td><strong>SYphilis</strong> (see 2006 CDC guidelines for follow-up recommendations and management of congenital syphilis)</td>
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<td><strong>PRIMARY, SECONDARY OR EARLY LATENT (&lt; 1 YEAR)</strong></td>
<td>• Saubradine penicillin G 2.4 million units IM in a single dose</td>
<td>(For penicillin allergic non-pregnant adult patient): Doxycycline 100 mg orally twice a day for 14 days OR Ceftriaxone 1 g daily IV or IM for 7-10 days OR Azithromycin 2 g orally once</td>
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<tr>
<td>Adults</td>
<td>• Saubradine penicillin G 50,000 units/kg IM, up to the adult dose of 2.4 million units, in a single dose</td>
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<td>Children</td>
<td>• Benzathine penicillin G 2.4 million units IM for 3 doses, 1 week apart (total 7.2 million units)</td>
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<tr>
<td>LATE LATENT (1-3 YEARS) OF UNKNOWN DURATION Adults</td>
<td>• Saubradine penicillin G 50,000 units/kg IM up to the adult dose of 2.4 million units, administered in three doses at 1 week intervals (total 150,000 units up to the adult total dose of 7.2 million units)</td>
<td>• Doxycycline 100 mg orally twice a day for 28 days for adults only</td>
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<tr>
<td>Children</td>
<td>• Benzathine penicillin G 2.4 million units IM for 3 doses, 1 week apart</td>
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<tr>
<td><strong>NEUROSYPHILIS</strong></td>
<td>• Aquous crystalline penicillin G 18 - 24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion, for 10-14 days</td>
<td>• Procaine penicillin 2.4 million units IM once daily plus probenecid 500 mg orally 4 times a day, both for 10-14 days</td>
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<tr>
<td>HIV INFECTION</td>
<td>For primary, 2nd and early latent syphilis: Treat as above. Some specialists recommend three doses.</td>
<td>The use of any alternative therapy in HIV infected patients has not been well studied, therefore the use of doxycycline, ceftriaxone and azithromycin must be undertaken with caution.</td>
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<td><strong>PREGNANCY</strong></td>
<td>Penicillin is the only recommended treatment for syphilis during pregnancy. Women who are allergic should be desensitized and then treated with penicillin. Dosages are the same as in non-pregnant patients for each stage of syphilis.</td>
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<td><strong>GONOCOCAL INFECTIONS</strong></td>
<td>Treat also for chlamydial infection if not ruled out by a sensitive test (nucleic acid amplification test)</td>
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<td><strong>ADULTS</strong></td>
<td>CERVIX, URETHRA, RECTUM</td>
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<tr>
<td>DISEASE</td>
<td>RECOMMENDED TREATMENT</td>
<td>ALTERNATIVES</td>
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<tr>
<td><strong>NONGONOCOCAL URETHRITIS</strong></td>
<td><em>Azithromycin</em> 1 g orally single dose OR <em>Doxycycline</em> 100 mg orally 2 times a day x 7 days</td>
<td><em>Erythromycin base</em> 500 mg orally 4 times a day for 7 days OR <em>Erythromycin ethylsuccinate</em> 800 mg orally 4 times a day for 7 days OR <em>Levofloxacin</em> 500 mg orally once a day for 7 days OR <em>Ofloxacin</em> 300 mg orally twice a day for 7 days OR <em>Levofloxacin</em> 500 mg orally once a day for 7 days</td>
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<tr>
<td><strong>EPIDIDYMITIS</strong></td>
<td><em>Ceftriaxone</em> 250 mg IM single dose PLUS <em>Doxycycline</em> 100 mg orally 2 times a day x 10 days</td>
<td><em>Ofloxacin</em> 300 mg orally once daily for 10 days OR <em>Levofloxacin</em> 500 mg orally once a day for 7 days</td>
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<tr>
<td><strong>PELVIC INFLAMMATORY DISEASE</strong> (outpatient management)</td>
<td><strong>REGIMEN A</strong></td>
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<tr>
<td><em>Ofloxacin</em> 400 mg orally 2 times a day for 14 days OR <em>Levofloxacin</em> 500 mg orally once a day for 14 days</td>
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<tr>
<td><strong>REGIMEN B</strong></td>
<td><em>Cefixime</em> 250 mg IM once OR Cefuroxime 250 mg IM plus probenecid 1 g orally once OR Other third generation cephalosporin PLUS <em>Doxycycline</em> 100 mg orally 2 times a day for 14 days</td>
<td></td>
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<tr>
<td><strong>FREQUENCY AND PID</strong></td>
<td>Patient should be hospitalized and treated with the appropriate recommended parenteral IV treatment (see CDC guidelines)</td>
<td></td>
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<tr>
<td><strong>CHANCROID</strong></td>
<td><em>Azithromycin</em> 1 g orally single dose OR <em>Ceftriaxone</em> 250 mg IM single dose OR <em>Ciprofloxacin</em> 500 mg orally 2 times a day for 3 days OR <em>Erythromycin base</em> 500 mg orally 1 times a day for 7 days (preferred by some experts if HIV co-infection)</td>
<td></td>
</tr>
<tr>
<td><strong>HERPES SIMPLEX VIRUS</strong> (for non-pregnant adults)</td>
<td>See CDC 2006 guidelines for the management of herpes in pregnancy and in the neonate</td>
<td></td>
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<tr>
<td>First clinical episode of genital herpes</td>
<td><em>Acyclovir</em> 400 mg orally 3 times a day for 7-10 days OR <em>Doxycycline</em> 200 mg orally 2 times a day for 7-10 days OR</td>
<td><em>Doxycycline</em> 100 mg orally 2 times a day for 14 days OR</td>
</tr>
<tr>
<td>Daily Suppressive therapy</td>
<td><em>Acyclovir</em> 400 mg orally 2 times a day OR <em>Doxycycline</em> 200 mg orally 2 times a day OR <em>Valacyclovir</em> 500 mg orally once a day OR 1 g orally once a day</td>
<td></td>
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<tr>
<td>Episodic Recurrent Infection</td>
<td><em>Acyclovir</em> 800 mg orally 2 times a day for 5 days OR <em>Doxycycline</em> 400 mg orally 2 times a day for 5 days OR <em>Valacyclovir</em> 1 g orally once a day OR</td>
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<tr>
<td>MIV INFECTION</td>
<td>Higher doses and/or longer therapy recommended. See 2006 CDC guidelines.</td>
<td>Malathion 0.5% lotion applied for 8-12 hours and washed off OR Ivermectin 250 μg/kg repeated in 2 weeks.</td>
</tr>
<tr>
<td><strong>PEDICULOSIS PUBIS</strong></td>
<td><em>Permethrin</em> 1% cream is applied to affected area and washed off after 10 minutes OR <em>Pyrethrins with piperonyl butoxide</em> applied to affected area and washed off after 10 minutes</td>
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<tr>
<td><strong>SCABIES</strong></td>
<td><em>Permethrin</em> 5% cream is applied to all areas of the body from the neck down and washed off after 8-14 hours OR <em>Ivermectin</em> 200 μg/kg orally, repeated in 2 weeks</td>
<td><em>Lindane</em> 1% of lotion or 30 g of cream applied daily to all areas of the body and thoroughly washed off after 8 hours.</td>
</tr>
<tr>
<td><strong>BACTERIAL VAGINOSIS (BV)</strong></td>
<td><em>Metronidazole</em> 500 mg orally 2 times a day for 7 days OR <em>Metronidazole gel</em> 0.75% intravag. once a day for 5 days OR <em>Clindamycin cream</em> 2% intravag. at bedtime for 7 days OR</td>
<td><em>Clindamycin</em> 300 mg orally 2 times a day for 7 days OR *Clindamycin oint. 10% intravag. at bedtime for 5 days OR</td>
</tr>
<tr>
<td><strong>PREGNANCY AND BV</strong></td>
<td><em>Metronidazole</em> 500 mg orally 2 times a day for 7 days OR</td>
<td><em>Clindamycin</em> 500 mg orally 2 times a day for 7 days OR</td>
</tr>
<tr>
<td><strong>TRICHOMONIASIS</strong></td>
<td><em>Metronidazole</em> 2 g orally single dose OR <em>Tinidazole</em> 2 g orally single dose</td>
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**GENITAL WARTS**

- **EXTERNAL**
  - **PROVIDER-ADMINISTERED**
    - Cryotherapy with liquid nitrogen or cryoprobe. Repeat applications every 1-2 weeks if necessary.
    - Trichloroacetic acid (TCA) or bichloroacetic acid (BCA) 60-90%. Apply small amount only to warts. Allow to dry. If excess amount applied, protect with tape, baking soda or liquid soap.
    - Epifibatide 16% ± 5% in a compound mixture of bismuth. Allow to air dry. Limit application to < 1 cm² and to ≤ 0.5 ml. Wash off 1-4 hours after application. Repeat weekly if necessary OR Surgical removal
  - **PATIENT-APPLIED**
    - *Fenoflox* 0.5% solution or gel. Apply 2 times a day for 3 days, followed by 4 days of no therapy. This cycle can be repeated as necessary for up to 6 times. Total wart area should not exceed 10 cm² and total volume applied daily not to exceed 0.5 ml.
    - Imiquimod 5% cream. Apply once daily at bedtime 3 times a week for up to 16 weeks. Wash treatment area with soap and water 6-12 hours after application.

- **URETHRAL MUCOSA**
  - **Cryotherapy with liquid nitrogen** OR *Podophyllin* 10%-25% (in a compound mixture of bismuth). Treatment area must be dry before contact with normal mucosa. Repeat weekly if necessary.

- **VAGINAL**
  - **Cryotherapy with liquid nitrogen** OR *Podophyllin* 10%-25% (in a compound mixture of bismuth). Treatment area must be dry before contact with normal mucosa. Repeat weekly if necessary.

- **ANAL**
  - **Cryotherapy with liquid nitrogen** OR *TCA or BCA* 60%-90%. Apply small amount only to warts. If excess amount applied, powder with talc, baking soda or liquid soap. Repeat weekly if necessary.
  - Many persons with anal warts may also have them in the rectal mucosa. Impacted rectal warts should be managed in consultation with a specialist.

- **ORAL**
  - **Cryotherapy with liquid nitrogen** OR Surgical removal
Patient Education and Partner Management

The following section will take you through:

- Education methods and tools for patients
- Partner Management
- Expedited Partner Therapy
- Partner Notification Referrals
- Iowa Disease Prevention Specialists
Patient Education

It is important to educate your sexually active patients on Chlamydia. They should be educated on what Chlamydia is and how its spread, the signs and symptoms of Chlamydia, how to find out if they have the disease, how serious it is, and how to avoid contracting Chlamydia.

Patients might also ask about abstinence or condom negotiation with a partner. Be prepared to give your patients ideas of the types of phrases that can be used to communicate to partners. The examples below can be used to negotiate abstinence or condom use:

Tell your patients:

“Sometimes you might feel pressured into doing something that you aren’t comfortable with or ready for, like having sex (or, having sex without a condom). There are ways to talk about it and be heard. Remember, it’s your body”

- I like you too, but I’m not ready…
- I’m glad you asked first, but…
- I care about you too, but no…
- I’m going to…
- I believe in…
- I’ve decided to…

Help your patients remember that they don’t HAVE to give a reason and they don’t need to argue. Remind them that, if it isn’t comfortable, they should respect their own feelings.

The following fact sheets from CDC and the Iowa Department of Public Health can be used for your information or for you to pass out to your patients.
What is chlamydia?

Chlamydia is a common sexually transmitted disease (STD) caused by the bacterium, *Chlamydia trachomatis*, which can damage a woman’s reproductive organs. Even though symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur “silently” before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an infected man.

■ How common is chlamydia?
Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. In 2006, 1,030,911 chlamydial infections were reported to CDC from 50 states and the District of Columbia. Under-reporting is substantial because most people with chlamydia are not aware of their infections and do not seek testing. Also, testing is often not done if patients are treated for their symptoms. An estimated 2,291,000 non-institutionalized U.S. civilians ages 14-39 are infected with chlamydia based on the U.S. National Health and Nutrition Examination Survey. Women are frequently re-infected if their sex partners are not treated.

■ How do people get chlamydia?
Chlamydia can be transmitted during vaginal, anal, or oral sex. Chlamydia can also be passed from an infected mother to her baby during vaginal childbirth.

Any sexually active person can be infected with chlamydia. The greater the number of sex partners, the greater the risk of infection. Because the cervix (opening to the uterus) of teenage girls and young women is not fully matured and is probably more susceptible to infection, they are at particularly high risk for infection if sexually active. Since chlamydia can be transmitted by oral or anal sex, men who have sex with men are also at risk for chlamydial infection.

■ What are the symptoms of chlamydia?
Chlamydia is known as a “silent” disease because about three quarters of infected women and about half of infected men have no symptoms. If symptoms do occur, they usually appear within 1 to 3 weeks after exposure.

In women, the bacteria initially infect the cervix and the urethra (urine canal). Women who have symptoms might have an abnormal vaginal discharge or a burning sensation when urinating. When the infection spreads from the cervix to the fallopian tubes (tubes that carry fertilized eggs from the ovaries to the uterus), some women still have no signs or symptoms; others have lower abdominal pain, low back pain, nausea, fever, pain during intercourse, or bleeding between menstrual periods. Chlamydial infection of the cervix can spread to the rectum.

Men with signs or symptoms might have a discharge from their penis or a burning sensation when urinating. Men might also have burning and itching around the opening of the penis. Pain and swelling in the testicles are uncommon.

Men or women who have receptive anal intercourse may acquire chlamydial infection in the rectum, which can cause rectal pain, discharge, or bleeding. Chlamydia can also be found in the throats of women and men having oral sex with an infected partner.

■ What complications can result from untreated chlamydia?
If untreated, chlamydial infections can progress to serious reproductive and other health problems with both short-term and long-term consequences. Like the disease itself, the damage that chlamydia causes is often “silent.”
In women, untreated infection can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). This happens in up to 40 percent of women with untreated chlamydia. PID can cause permanent damage to the fallopian tubes, uterus, and surrounding tissues. The damage can lead to chronic pelvic pain, infertility, and potentially fatal ectopic pregnancy (pregnancy outside the uterus). Women infected with chlamydia are up to five times more likely to become infected with HIV, if exposed.

To help prevent the serious consequences of chlamydia, screening at least annually for chlamydia is recommended for all sexually active women age 25 years and younger. An annual screening test also is recommended for older women with risk factors for chlamydia (a new sex partner or multiple sex partners). All pregnant women should have a screening test for chlamydia.

Complications among men are rare. Infection sometimes spreads to the epididymis (the tube that carries sperm from the testis), causing pain, fever, and, rarely, sterility. Rarely, genital chlamydial infection can cause arthritis that can be accompanied by skin lesions and inflammation of the eye and urethra (Reiter’s syndrome).

How does chlamydia affect a pregnant woman and her baby?

In pregnant women, there is some evidence that untreated chlamydial infections can lead to premature delivery. Babies who are born to infected mothers can get chlamydial infections in their eyes and respiratory tracts. Chlamydia is a leading cause of early infant pneumonia and conjunctivitis (pink eye) in newborns.

How is chlamydia diagnosed?

There are laboratory tests to diagnose chlamydia. Some can be performed on urine, other tests require that a specimen be collected from a site such as the penis or cervix.

What is the treatment for chlamydia?

Chlamydia can be easily treated and cured with antibiotics. A single dose of azithromycin or a week of doxycycline (twice daily) are the most commonly used treatments. HIV-positive persons with chlamydia should receive the same treatment as those who are HIV negative.

All sex partners should be evaluated, tested, and treated. Persons with chlamydia should abstain from sexual intercourse until they and their sex partners have completed treatment, otherwise re-infection is possible.

Women whose sex partners have not been appropriately treated are at high risk for re-infection. Having multiple infections increases a woman’s risk of serious reproductive health complications, including infertility. Retesting should be encouraged for women three to four months after treatment. This is especially true if a woman does not know if her sex partner received treatment.

How can chlamydia be prevented?

The surest way to avoid transmission of STDs is to abstain from sexual contact, or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected.

Latex male condoms, when used consistently and correctly, can reduce the risk of transmission of chlamydia. CDC recommends yearly chlamydia testing of all sexually active women age 25 or younger, older women with risk factors for chlamydial infections (those who have a new sex partner or multiple sex partners), and all pregnant women. An appropriate sexual risk assessment by a health care provider should always be conducted and may indicate more frequent screening for some women.

Any genital symptoms such as an unusual sore, discharge with odor, burning during urination, or bleeding between menstrual cycles could mean an STD infection. If a woman has any of these symptoms, she should stop having sex and consult a health care provider immediately. Treating STDs early can prevent PID. Women who are told they have an STD and are treated for it should notify all of their recent sex partners (sex partners within the preceding 60 days) so they can see a health care provider and be evaluated for STDs. Sexual activity should not resume until all sex partners have been examined and, if necessary, treated.

FOR MORE INFORMATION:
Division of STD Prevention (DSTD)
Centers for Disease Control and Prevention
http://www.cdc.gov/std/

CDC-INFO Contact Center
1-800-CDC-INFO (1-800-232-4636)
Email: cdcinfo@cdc.gov

American Social Health Association (ASHA)
1-800-783-9877
www.ashastd.org
CHLAMYDIA FACTS

(Caused by Chlamydia trachomatis, a bacteria)

SIGNS AND SYMPTOMS

- Usually begin 7-21 days after exposure
- Most people have no symptoms

Chlamydia Symptoms for Women:

- Most women have no symptoms
- Abnormal vaginal bleeding, discharge or itching
- Burning or pain during urination
- More pain than usual during periods
- Cramps and pain in lower abdomen
- Anal discomfort, itching or discharge

Chlamydia Symptoms for Men:

- Most men have no symptoms
- Watery or thin white discharge from penis
- Burning or pain during urination or bowel movement
- Anal discomfort, itching or discharge

PREVENTION

Recommendations to reduce the spread of Chlamydia infection:

- Abstinence is the only sure way to prevent infection
- Always use latex condoms consistently and correctly during vaginal, oral and anal sex
- Limit your number of sex partners
- To prevent re-infection, notify all sex partners immediately to make sure they are tested and treated

TREATMENT

- Can be cured with proper medication

A PERSON CAN BE RE-INFECTED AFTER TREATMENT, SO...

- All persons whom you have had sex with during the 60 days before onset of symptoms or during the 60 days before the time of your diagnosis should immediately be evaluated and treated
- To avoid re-infection, do not have sex until you and all of your sex partner(s) are:
  - 7 days past the single-dose treatment
  - finished with the 7-day treatment

COMPLICATIONS

If left untreated, Chlamydia can:

- Lead to pelvic inflammatory disease (PID) in women
- Lead to epididymitis (swollen testicles) in men
- Lead to ectopic (tubal) pregnancy
- Lead to infertility in men and women
- Spread to other sex partners

Chlamydia and pregnancy:

- Can be passed to newborn during childbirth and cause serious eye infection or pneumonia
- Can lead to premature delivery and low birth weight

FOR MORE INFORMATION, CONTACT:

Iowa Department of Public Health
STD PROGRAM
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319-0075
(515) 281-3031
http://www.idph.state.ia.us/adper/std_control.asp
Partner Management

Patients should be instructed to refer any sex partner(s) for evaluation, testing and treatment. The following recommendations on exposure intervals are based on limited evaluation.

Chlamydia:
- Refer all partners from the last 60 days before onset of symptoms for routine history and exam.
- Treat all partners from the last 60 days before onset of symptoms.
- If no partners in last 60 days, treat most recent partner.
- If asymptomatic, treat all partners from 60 days prior to treatment of original patient.

Gonorrhea:
- Refer all partners from the last 60 days before onset of symptoms for routine history and exam.
- Treat all partners from the last 60 days before onset of symptoms.
- If no partners in last 60 days, treat most recent partner.
- If the case is asymptomatic, treat all partners from 60 days prior to treatment of original patient.

Patients should be encouraged to abstain from sexual intercourse until they and their sex partners have completed treatment. Abstinence should be continued until 7 days after a single-dose regimen or after completion of a 7 day regimen. Timely treatment of sex partners is essential for decreasing the risk of re-infecting the original patient.
Expedited Partner Therapy (EPT)

On July 1, 2008, Expedited Partner Therapy (EPT), also known as became legal in the state of Iowa. EPT is legal in many cities and states throughout the United States. There are different types of EPT. Partner Delivered Therapy (PDT) is the practice of treating the sex partner(s) of persons with STDs by allowing the infected patient to deliver oral medication or a prescription script to exposed partners. Directly Observed Therapy (DOT) is the practice of treating the sex partner(s) of persons with STDs by allowing a public health professional to deliver oral medication or a script to exposed partners. Iowa law allows both PDT and DOT. The specific language in the Iowa Code for EPT is provided in the Iowa Law and Confidentiality section of this toolkit under Section 139A.41 Chlamydia and Gonorrhea.

- Studies show EPT reduces re-infection rates by about 20%.
- Studies show that providers use EPT frequently – some up to 50% of the time.
- Since repeated re-infection increases the chances of serious health consequences and the likelihood of the bacteria developing resistance to treatment, it is essential to reduce re-infection rates as much as possible.
- EPT is associated with a higher likelihood of partner notification (letting sex partners know they have been exposed to an infection) when compared to other forms of un-assisted partner management.
- EPT is associated with a significant reduction in the rates of patients engaging in continued sexual encounters with known untreated partners.
- While allergic reactions in partners treated without direct medical supervision can occur, studies indicate that the oral antibiotics used for EPT generally create mild adverse outcomes if any at all. No serious allergic reactions as a result of EPT have been reported to the CDC.
- The most commonly reported adverse outcome is mild gastrointestinal intolerance.
- Always send information about STDs and the medication you are giving with the patient to give to the partner. That way, the partner will be alerted to seek an STD screening for other infections and understand the risks of taking the medication.

**IMPORTANT!**

If your clinic receives public funding such as Medicaid or is supplied with publicly purchased STD medications, make sure to check the regulations for reimbursement/dispersing medication before billing for or offering medications for partners. In this situation, it is probably best to offer a script for the partner(s).

**Information about EPT changes rapidly. For the most recent guidance and printable information visit:**

http://www.idph.state.ia.us/adper/std_control.asp
Partner Notification Referrals

There are many different methods to perform partner notification referrals and counseling. It can be done by the patient themselves, by the provider, or by state or local Disease Prevention Specialists (DPS). DPS Partner Notification, also called “provider referral”, is a safe and confidential way for people to locate and inform current and past partners that they may have been exposed to an infection.

DPS assisted Partner Notification is one of the best ways to stop the spread of infection and has been used with STDs for more than 30 years.

- The DPS can assist in finding people who have STDs, but may not know it.
- Iowa law allows the Iowa Department of Public Health and local health departments to offer partner notification assistance to every person with an STD or HIV.
- The decision to participate in partner services is up to each individual and is completely confidential.

A patient might need time to process the situation before being willing to proceed with partner notification.

1. Tell the patient that you will give him/her some time to think it through, and will call or see him/her in the office within the next week to discuss it again.
2. Find out how the patient wants to be contacted. Set up an agreed time, date and method (e.g. office visit, phone call, etc.) to follow up.
3. Send the patient home with information on how to access partner notification services. Schedule another appointment in 3 months to retest the patient.
4. Make a note to continue dialogue on prevention and partner notification at that visit as well.

A Confidential Partner Record helps identify the partners of the patient:

Many public clinics use the form provided on the next page to collect partner information. HERE’S HOW:

- If the patient is positive, the form can be provided to a DPS.
- If the patient is negative, the form can be shredded. PLUS...
- The form is a good lead-in to discussing sexual health with a patient:

  “I see you’ve had two sexual partners in the last year. What questions do you have about sexual health?”

A DPS Flyer and DPS Map are also included in the following pages and can be helpful to handout and discuss with patients during the exam.
Confidential Partner Notification

It is important that all the people you are having sex be tested and treated. This includes all of your partners in the last 3 months. Please fill in the form below, so that testing and treatment can be offered to them. This is completely confidential or private. Your name and information will not be shared with anyone.

1. Name ___________________________ Male________ Female_________
   Address ___________________________________________________
   Phone number(s)______________________Age / birth date __________
   When did you have sex? First time_________ Last time? __________
   Where do they work or go to school? ____________________________
   What do they look like? _______________________________________
   Have they been tested or treated? _______________________________

2. Name ___________________________ Male________ Female_________
   Address ___________________________________________________
   Phone number(s)______________________Age / birth date __________
   When did you have sex? First time_________ Last time? __________
   Where do they work or go to school? ____________________________
   What do they look like? _______________________________________
   Have they been tested or treated? _______________________________

3. Name ___________________________ Male________ Female_________
   Address ___________________________________________________
   Phone number(s)______________________Age / birth date __________
   When did you have sex? First time_________ Last time? __________
   Where do they work or go to school? ____________________________
   What do they look like? _______________________________________
   Have they been tested or treated? _______________________________

4. Name ___________________________ Male________ Female_________
   Address ___________________________________________________
   Phone number(s)______________________Age / birth date __________
   When did you have sex? First time_________ Last time? __________
   Where do they work or go to school? ____________________________
   What do they look like? _______________________________________
   Have they been tested or treated? _______________________________

Please turn the form over to list additional sex partners.
Your health care provider or other health professional is giving you this flyer to let you know who Disease Prevention Specialists are (DPS), what they do, and when you might hear from a DPS.

If you are diagnosed with a treatable sexually transmitted disease (STD) such as Syphilis, Gonorrhea, Chlamydia, or HIV a DPS from the local or state health department will follow-up with you. Health care providers and laboratories are required to report such infections to the health department to assist with disease control and prevention. The DPS will first get information from your health care provider to be sure to know how to reach you and be sure you were given the right medication. The DPS will then contact you to see if you have any questions and talk to you about the infection. This will help to ensure that you thoroughly understand the infection; know how long you may be able to spread it to other people; learn how to lower your risk of getting this and other STDs in the future; understand your prescribed treatment; and know when you need follow-up tests to ensure the treatment was effective.

The DPS will also assist with confidentially informing all of your sex partners who may have passed the infection to you, or vice versa. It is very important that partners receive medical care to help prevent these infections from getting worse and to prevent the further spread of STDs. Testing and treating your partners also helps keep you from getting re-infected by an untreated sex partner. Most partners do not know that they have been exposed to, or are infected with an STD since people do not usually have symptoms until the infection is really bad.

DPS carefully protect confidentiality as it relates to everyone associated with the infection at all times as required by law. DPS are trained public health workers, whose job is to assist with protecting the health of the community. DPS DO NOT share any information including names with the people they talk to.

We hope the word spreads that DPS are there to help keep the community healthy. Thank you in advance for your time and help. For more information, please call: 515-281-3031 or visit www.idph.state.ia.us/adper/std_control.asp

Thank you again.
References and CME'S


DR Blake et al, Improving Participation in Chlamydia Screening Programs: Perspectives of High Risk Youth, Archives of Pediatric Adolescent Medicine, 2003, June; 157(6):523-9


“STRATEGIES FOR EFFECTIVE CHLAMYDIA SCREENING” QUESTIONNAIRE

Office Name: ___________________________    Date: ___________________________

1. Provider Type (circle one)
   - Physician
   - Nurse Practitioner
   - Physician’s Assistant
   - RN
   - LPN
   - Other ___________________________ (Please describe)

2. Clinic Type (circle one)
   - Family Practice Clinic
   - Adolescent Clinic
   - Pediatric Clinic
   - Obstetric/Gynecologic Clinic
   - Hospital/ER
   - Other ___________________________ (Please describe)

3. What year did you complete your specialty training? _______

4. What is your gender? (Circle one)    FEMALE   MALE

5. About what percent of general physical exams are your FEMALE patients given some time alone with the provider?
   - 13 years old ____%  16 years old ____%  older than 18 years ____%
   - 14 years old ____%  17 years old ____%
   - 15 years old ____%  18 years old ____%

6. About what percent of general physical exams are your MALE patients given some time alone with the provider?
   - 13 years old ____%  16 years old ____%  older than 18 years ____%
   - 14 years old ____%  17 years old ____%
   - 15 years old ____%  18 years old ____%

7. About what percent of general physical exams are your FEMALE patients asked about sexual behavior?
   - 13 years old ____%  16 years old ____%  older than 18 years ____%
   - 14 years old ____%  17 years old ____%
   - 15 years old ____%  18 years old ____%

8. About what percent of general physical exams are your MALE patients asked about sexual behavior?
   - 13 years old ____%  16 years old ____%  older than 18 years ____%
   - 14 years old ____%  17 years old ____%
   - 15 years old ____%  18 years old ____%

9. About what percent of sexually active FEMALE patients do you offer STD testing to? _____%

10. About what percent of sexually active MALE patients do you offer STD testing to? _____%

11. What STD testing do you routinely offer? (circle all that apply)
   - Chlamydia
   - Gonorrhea
   - Syphilis
   - Herpes
   - Trich
   - HPV
   - HIV

12. Were you aware of urine-based Chlamydia and Gonorrhea nucleic acid amplification tests before participating in this activity? (circle one)    YES   NO
13. During what types of exams do you regularly offer FEMALES STD testing? (circle all that apply)
   - Annual Physical during PAP
   - Annual Physical without PAP
   - Sports Physical
   - When symptomatic

14. During what types of exams do you regularly offer MALES STD testing? (circle all that apply)
   - Annual Physical
   - Sports Physical
   - When symptomatic

15. Do you intend to increase the proportion of general physical exams where the following FEMALE patients are provided some time alone with the provider?
   - 13 to 14 years old (circle one) YES NO
   - 15 to 19 years old (circle one) YES NO
   - 18 years and older (circle one) YES NO

16. Do you intend to increase the proportion of general physical exams where the following MALE patients are provided some time alone with the provider?
   - 13 to 14 years old (circle one) YES NO
   - 15 to 19 years old (circle one) YES NO
   - 18 years and older (circle one) YES NO

17. Do you intend to increase the proportion of general physical exams where the following FEMALE patients are asked about sexual behavior?
   - 13 to 14 years old (circle one) YES NO
   - 15 to 19 years old (circle one) YES NO
   - 18 years and older (circle one) YES NO

18. Do you intend to increase the proportion of general physical exams where the following MALE patients are asked about sexual behavior?
   - 13 to 14 years old (circle one) YES NO
   - 15 to 19 years old (circle one) YES NO
   - 18 years and older (circle one) YES NO

19. Do you intend to increase the proportion of sexually active FEMALE patients to whom you offer an STD screening? (circle one) YES NO

20. Do you intend to increase the proportion of sexually active MALE patients to whom you offer an STD screening? (circle one) YES NO

21. If you answered “yes” to #19 and/or #20: What STD testing do you intend to offer more frequently? (circle all that apply)
   - Chlamydia
   - Gonorrhea
   - Syphilis
   - Herpes
   - Trich
   - HPV
   - HIV

22. Do you intend to increase the proportion of Chlamydia and Gonorrhea nucleic acid amplification tests that you order? (circle one) YES NO

23. Can we contact you in 2 to 3 months to enquire about your changes in sexual health care practices? (circle one) YES NO
24. This activity fulfilled the stated CME objectives. (circle one) YES  NO

25. The sections were effectively written. (circle one) YES  NO

26. How could we have improved the activity?

27. What CME topics related to STDs would you like to see in the future?

**Designation Statement:** The Saint Louis STD/HIV Prevention Training Center designates this educational Activity or a maximum of 2.0 AMA PRA™ Category 1 credit. Physicians should only claim credit Commensurate with their participation in the activity.

Name: _______________________________ License Number: _______________________
Address: _____________________________ License State: __________________________
City/State/Zip: ________________________ Credentials: ____________________________
Phone: _______________________________ E-mail: _______________________________

I confirm that I participated in the session “Strategies for Effective Chlamydia Screening”. ________________

Signature of Participant

Send the completed CME Questionnaire to:

Deloris Rother, MPH, Manager Prevention Training Center
St. Louis STD/HIV Prevention Training Center
Washington University School of Medicine
660 S. Euclid Avenue, Campus Box 8051
St. Louis, MO  63110-1093
Telephone: (314) 747-0294
FAX: (314) 362-1872
Std/hiv@im.wustl.edu

A certificate of credit will be mailed to you. Retain a copy of your certificate for your records. This activity was reviewed on August 22, 2008. The expiration date for this activity is September 1, 2009.