**Gonorrhea Query Letter**

*Insert name of lab* reported a positive gonorrhea result to the local public health authority (health department) or the Oregon Health Authority for one of your patients. The health department follows up on all reported cases of gonorrhea.

Please complete this report *within one business day* of gonorrhea diagnosis and return it to *insert health department* via fax at *insert fax number* or report by telephone at *insert phone number* (voicemail is confidential). Feel free to contact *insert health department STD contact person* with questions regarding care of this patient. Guidance on gonorrhea treatment and expedited partner therapy is provided below for your reference.

*See the* [*2020 Update to CDC's Treatment for Gonococcal Infections*](https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm?s_cid=mm6950a6_w&ACSTrackingID=USCDCNPIN_122-DM44847&ACSTrackingLabel=CDC%20Releases%20Updated%20Gonorrhea%20Treatment%20Recommendations%20&deliveryName=USCDCNPIN_122-DM44847) *for additional information on gonorrhea treatment and expedited partner therapy recommendations.*

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| Uncomplicated Infection | Recommended Gonorrhea Treatment | Treatment if Cephalosporin/Penicillin- Allergic |
| Urogenital, Rectal, or Pharyngeal Gonorrhea | Ceftriaxone 500 mg IM for persons <300 lb   * Ceftriaxone 1 g IM for persons weighing ≥300 lb   If chlamydia has not been excluded, add doxycycline 100 mg orally twice daily for 7 days   * If pregnancy, doxycycline allergy, or adherence issues are present, add azithromycin 1 g as a single dose instead of doxycycline | Gentamicin 240 mg IM  PLUS  Azithromycin 2 grams orally as a single dose   * Does not treat pharyngeal gonorrhea |

Expedited partner therapy (EPT) is the practice of prescribing or dispensing an antibiotic for the treatment of a sexually transmitted disease to the partner of a patient without first examining that partner. EPT was authorized by the Oregon Legislature in 2009 ([ORS 676.350](https://www.oregonlegislature.gov/bills_laws/ors/ors676.html)).

Partners of patients diagnosed with chlamydia and/or gonorrhea are eligible to receive EPT. All partners in the 60 days prior to diagnosis should be considered at risk for infection and treated. If the patient reports no partners in the previous 60 days, the most recent partner should be treated.

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| Expedited Partner Therapy for Gonorrhea |
| Cefixime 800 mg orally as a single dose   * If chlamydia has not been excluded, add doxycycline 100 mg orally twice daily for 7 days |

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| **PATIENT INFORMATION** | | |
| Patient Name |  | |
| Date of Birth |  | |
| Home Address |  | |
| Phone Number |  | |
| Alternate Phone Number |  | |
| Race  (choose all that apply) | White  Black  Asian  American Indian/ Alaska Native | Pacific Islander  Other  Unknown |
| Hispanic Ethnicity | Yes  No  Unknown | |
| Gender | Male  Female  Trans Male  Trans Female | Non-Binary  Other |
| Pregnancy Status | Pregnant – Est. Delivery Date:  (mm/dd/yyyy) \_\_\_\_\_\_\_\_\_  Not Pregnant  Unknown  N/A | |
| Gender of Sex Partners  (choose all that apply) | Male  Female  Unknown | |
| HIV Status | Positive  Negative – Date of Last Test:  (mm/dd/yyyy) \_\_\_\_\_\_\_\_\_  Unknown | |
| **VISIT INFORMATION** | | |
| Reason for Visit |  | |
| Symptomatic  (choose all that apply) | Yes – Symptoms and Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No | |
| Complications  (choose all that apply) | Disseminated gonococcal infection  Epididymitis  Gonococcal ophthalmia  Pelvic inflammatory disease | |
| Lab Result | Positive  Negative | |
| Specimen Type  (choose all that apply) | Urine  Urethral swab  Endocervical/vaginal swab | Rectal swab  Pharyngeal swab |
| Treatment Provided *(see pg. 1)*  (choose all that apply) | Ceftriaxone 500 mg IM Date: *\_\_\_\_\_\_\_\_*  Cefixime 800 mg orally Date: *\_\_\_\_\_\_\_\_*  Doxycycline 100 mg twice daily x 7 days Date: *\_\_\_\_\_\_\_*  Azithromycin 1 g Date: *\_\_\_\_\_\_\_\_*  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: *\_\_\_\_\_\_\_*  None | |
| EPT Provided *(see pg. 1)* | Yes – Number of Partners Treated: \_\_\_\_\_  No | |
| Additional Concerns for Patient | Housing  Transportation  Mental Health  Substance Use | None  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PROVIDER INFORMATION** | | |
| Provider Name |  | |
| Phone Number |  | |