



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

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

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

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

Street Address _____ City _____ State ____ ZIP _____

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

2. Type of STD with which the OP has been diagnosed (mark all that apply):

- Syphilis – Primary, Secondary, or Early Latent HIV AIDS
 Syphilis – Late or Latent of Unknown Duration Gonorrhea Chlamydia

3. High risk category to which the OP belongs (mark all that apply):

- Currently Pregnant (EDD: _____) History of ≥ 2 STDs within 12 Months
 Age 13 – 17 Years Exchanges Sex for Money, Food, Shelter, Drugs, and/or Clothing

4. Partner’s information. If OP has multiple partners, please fill out one form for each partner.

You must provide at least name and one valid method of contact. Fill out this section as completely as possible.

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

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

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

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

Email address: _____ Chat Room Venue & ID: _____

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

Description of Dwelling: _____ Description of Vehicle: _____

Hangouts: _____ Workplace: _____ School: _____

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

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

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

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

5. Type of partner services requested (select one):

- Dual Disclosure (OP wishes to inform partner himself/herself with Health Department assistance)
 Anonymous Third Party Notification (Health Department will not disclose OP’s identity to partner)

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



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

SECTION B – TO BE COMPLETED BY HEALTH DEPARTMENT STAFF

1. Name of Referring Facility/Provider: _____

Phone Number: _____ Fax Number: _____

Date Referral Received: _____ Date Services Initiated: _____

2. Original patient (OP):

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

3. Type of STD with which the OP has been diagnosed (mark all that apply):

- Syphilis – Primary, Secondary, or Early Latent HIV AIDS
- Syphilis – Late or Latent of Unknown Duration Gonorrhea Chlamydia

4. Partner for which services were requested:

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

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

5. Disposition of referral:

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

6. Contact attempts:

- _____ _____
- _____ _____

7. Comments: _____

8. Completed by:

Name: _____ Title: _____

Phone Number: _____ Date of Completion: _____