**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Sending Health Authority Contact Information]

**We have been informed that the following:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Address:** |  |
| **Phone Number:** |  |
| **E-mail:** |  |

**Has been a contact to:**

□ Chlamydia □ Gonorrhea □ Syphilis □ HIV

**Defining Characteristics:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Age:** | **Sex/Gender:** | | **Ethnicity/Race:** | | |
| **Height:** | | **Build:** | | **Hair:** | **Eyes:** |
| **Other Defining Characteristics:** | | | | | |
| **Alleged Exposure Date:** | | | | | |
| **Notes:** | | | | | |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Sender requests information below to be completed and returned**: □ Yes □ No |

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Check all that apply***

□ Has been informed □ Moved from jurisdiction □ Unable to locate

□ Tested positive □ Tested negative

□ Treated (specify treatment and date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

H219 – Notification of Contact to Sexually Transmitted Infection *Updated August 2018*