Memorandum of Understanding
between
Missouri Department of Health and Senior Services
and

Facility/Provider Name: City of Columbia on behalf of Columbia/Boone County Public Health & Human Services (CBCPHHS)

This Memorandum of Understanding (MOU) between the Missouri Department of Health and Senior Services, hereinafter referred to as "DHSS," acting in its Public Health Authority capacity, and

City of Columbia on behalf of the (CBCPHHS) hereinafter referred to as "Provider," a hybrid HIPAA covered entity as defined in 45 CFR 160.103, is entered into for the purpose of:

☒ provision of STD medications. The MOU outlines the requirements for Providers to receive STD medications from DHSS. **See page 2: STD Testing Program Medication Provision.**

☒ collaborating to reduce Sexually Transmitted Disease (STD) incidence. The MOU outlines the activities of the DHSS STD Testing Program, which includes screening selected groups for chlamydia and gonorrhea and implementing interventions for those infected as stated in the *2018 STD Testing Program Procedural Guidelines,* Attachment A, which is attached hereto and is incorporated by reference as if fully set forth herein. **See page 3: STD Testing Program Participation.**

This MOU is established to maximize collaboration and defines the roles and responsibilities of DHSS and the Provider. This MOU shall be in effect for a one-year period beginning January 1, 2020, and ending December 31, 2020. Either party may terminate this MOU without cause, upon thirty (30) calendar days written notice to the other party.

Signed: _____ Date: _____
Division of Administration Director or Designee

SKD

Signed: _____ Date: _____
~~Administrator~~ Name
Provider
John Glascock, City Manager

Approved as to form:

City Counselor

Facility/Provider Name: City of Columbia

STD Testing Program Medication Provision

DHSS agrees to provide the following to the Provider:

- STD medications, as available and as resources allow.
- Referrals for infected patients and partners to DHSS's Disease Intervention Specialists (DIS) as resources allow.
- Record keeping forms required by the program through DHSS including the *STD Medication Report* and *Record of Drugs.*
- Technical assistance regarding CDC treatment recommendations.

Provider agrees to:

- Follow the confidentiality policies in the Missouri Code of State Regulations 19 CSR 20-20.075 and also any applicable confidentiality laws, including §§ 192.067 and 191.656, RSMo.
- Treat all clients diagnosed with syphilis, chlamydia and/or gonorrhea as well as individuals exposed to those infections in accordance with the Provider's standing orders, in accordance with the current edition of CDC's *Sexually Transmitted Disease Treatment Guidelines*, which can be found at http://www.cdc.gov/std/treatment/default.htm.
- Order medication according to the *2018 STD Testing Program Procedural Guidelines.*
- Comply with State of Missouri reporting statutes and rules regarding communicable diseases under Missouri 19 CSR 20-20.020.
- Maintain complete *Record of Drugs* and make available to DHSS upon request.
- Not seek reimbursement from either the patient or a third-party including insurance companies for in-kind services and items provided by DHSS through this MOU.

~~Administrator~~ **Initials and Date:** _____
Provider

Facility/Provider Name: City of Columbia

STD Testing Program Participation

DHSS agrees to provide the following to the Provider:

- *2018 STD Testing Program Procedural Guidelines.*
- Specimen collection devices, as available and as resources allow determined by DHSS.
- Training opportunities, educational materials, and applicable guidelines.
- Periodic quality assurance visits.
- Quarterly reports of testing activity.

Provider agrees to:

- Follow the *2018 STD Testing Program Procedural Guidelines* provided by DHSS.
- Collect and submit laboratory specimens according to STD Testing Program screening criteria determined by DHSS and according to the STD testing procedures developed by the Missouri State Public Health Laboratory (SPHL) and the manufacturer of the STD collection device (see Appendix B5 in the *2018 STD Testing Program Procedural Guidelines).*
- Ensure accuracy and completeness of all laboratory requisitions (lab slips) submitted to the SPHL including all information required by DHSS.
- Conduct Risk Reduction Counseling as described in the *2018 STD Testing Program Procedural Guidelines.*
- Notify the DHSS STD Testing Coordinator within fourteen (14) business days of any Provider changes that would impact program operations including, but not limited to staffing changes and changes in testing volume.
- Comply and participate in quality assurance site visits by DHSS and provide access to all STD Testing Program charts and records for review by DHSS.
- Receive approval from the DHSS STD Testing Coordinator prior to any outreach or other testing that would significantly increase the number of specimens submitted to the SPHL by the Provider.
- Not seek reimbursement from either the patient or a third-party including insurance companies for in-kind services and items provided by DHSS through this MOU.

During the MOU period, DHSS will assess the Provider for compliance to verify continued enrollment. Assessment factors may include but are not limited to positivity rates, adherence to screening criteria, client insurance information collection, number of uninsured and underinsured individuals served, results of quality assessment visits, availability of project funding, and general adherence to this MOU.

~~**Administrator**~~ **Initials and Date:** _____
Provider

2018 STD Testing Program Procedural Guidelines

Prepared by:
Bureau of HIV, STD and Hepatitis
930 Wildwood Drive
Jefferson City, MO 65109
Phone: 573-751-6439
www.health.mo.gov

Missouri DHSS Department of Health and Senior Services

2018 STD Testing Program Procedural Guidelines

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Introduction to the Missouri STD Testing Program

In an effort to reduce morbidity, healthcare costs, and the subsequent complications associated with Sexually Transmitted Diseases (STDs), the State of Missouri currently offers various prevention and control programs to health care agencies and their clients. The STD Testing Program provides chlamydia and gonorrhea (CT/GC) testing resources to health care agencies for clients who meet criteria, as well as treatment and follow-up services for infected clients and their sex partners. The STD Testing Program provides medication to non-profit health care providers (Medication Only sites) for the treatment of infected clients and their sex partners.

These guidelines provide information regarding program enrollment and procedural guidance for participation in the Program. Please see the Table of Contents and Appendices List for quick reference hyperlinks.

Enrollment

Program enrollment is offered to health care agencies, such as local public health agencies and community based organizations throughout Missouri, based on disease prevalence among women ages 15 to 24, provision of STD prevention services to certain uninsured categories of clients, and available funding. All providers are required to enter into a Memorandum of Understanding (MOU) that outlines the specific responsibilities of enrollment and are required to adhere to these Procedural Guidelines. Providers are reviewed for re-enrollment in the Program at the beginning of each calendar year. Enrollment is dependent upon a current MOU, which must be signed and submitted to the Department of Health and Senior Services (DHSS) before medications or test kits can be ordered or submitted to the State Public Health Laboratory (SPHL). In addition, all providers must meet and maintain a minimum of 3% chlamydia positivity rate among females ages 15 to 24. Retention of sites in the program will depend on this positivity rate, insurance status of clientele, and available funding, as determined by DHSS.

Medication Only sites must also submit signed MOUs to DHSS prior to ordering medications and keep current records as outlined in the MOU.

Program Evaluation

Enrolled Program providers are evaluated on an as needed and/or annual basis. This evaluation includes, but is not limited to: positivity rates in women ages 15 to 24, percentage of visits provided to under- and uninsured clients, unsatisfactory specimen submission rates, appropriate medication and testing resource management, compliance with the current signed MOU and adherence to these Procedural Guidelines.

Medication Only sites are evaluated on an as needed basis. This review includes appropriate medication management as evidenced by accurate submission of Medication Reports, proper storage, use of medications to avoid waste and compliance with the current executed MOU and adherence to the sections of these Procedural Guidelines pertaining to Medication Only sites. Program site selection and continuation is determined at DHSS discretion.

Expectations

Program providers are required to:

- Meet and maintain a minimum of 3% chlamydia positivity rate among females ages 15 to 24. Special considerations will be made for agencies that provide care primarily to men who have sex with men (MSM).
- Maintain at least a 90% accuracy rate on completion of core data elements on the State Public Health Laboratory (SPHL) Immunology Test Request form.
- Have no more than 2% unsatisfactory specimens.
- Have no out-of-criteria submissions (submissions not meeting chlamydia/gonorrhea screening/testing criteria).
- Have no more than fourteen days between specimen collection and treatment or referral for treatment of a positive chlamydia/gonorrhea (CT/GC) client.
- Ask and record insurance information (e.g. private, Medicaid, none) for each client on the SPHL Immunology Test Request form. The provider is NOT required to bill insurance to maintain STD Testing Program participation. No more than 30% of Immunology Test Request forms should indicate "unknown" insurance status.
- Have written protocols and/or procedures for testing, treatment or treatment referral, and follow-up for infected clients and their sex partners.
- Obtain a sexual health history including a genitourinary, sexual, and social history to assess the client's risk for CT/GC infection before providing services in a clinical setting.
- Submit Disease Case Report (CD-1) (Appendix C-4) forms for all chlamydia, gonorrhea, syphilis, and HIV positive test results to DHSS within reportable timelines with treatment information, if known and applicable.

Testing Program Criteria

Chlamydia and Gonorrhea Testing:

Screening Criteria (One test per 12 month period):

- **Females 15-24 years AND ≥ 1 sex partner in the last 12 months**
- **Females 25-44 years AND**
  EITHER a new sex partner in the last 60 days OR ≥2 sex partners (last 12 months)
- **Males with ≥1 male sex partner in the last 12 months** (test relevant exposure site per client's sexual history, e.g., perform rectal screening if client reports receptive anal intercourse in the last 12 months)

Testing Criteria (Males and Females ≥ 12 years of age):

- **A contact to CT/GC positive client** (within the preceding 60 days of the original client's positive test or as the last known sex partner)
- **Rescreen** 3-12 months post-treatment to verify that the client has not been re-infected
- **Symptomatic** (Urethritis: frequency of urination, burning/dysuria, discharge; Mucopurulent cervicitis (MPC)/cervicitis; cervical friability; PID suspicion)

Syphilis/HIV Testing:

- **Permitted to screen and test all individuals for syphilis.**
- **Encouraged to screen and test all individuals age 13-64 for HIV as part of routine testing. (www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm)**

Alternative resources must be utilized for clients not meeting criteria.

Note: Screening Criteria refers to annual CT/GC testing – not requiring symptoms or known exposure. Any person, greater than 12 years of age, can be tested if meeting the **Testing Criteria**, even if they have already been previously tested in the past year. Clients *screened* in the previous 12 months can only be retested if meeting **Testing Criteria**.

Criteria Exclusions:

Testing specifically because a ***partner*** has had multiple and/or new partners is not permissible.

Test of Cure (retesting to verify that medication has been effective) is not recommended by the Centers for Disease Control and Prevention (CDC) and is not permissible unless the client is pregnant, treatment adherence is in question, symptoms persist, or reinfection is suspected.

Exception: *Pharyngeal gonorrhea - CDC recommends a test of cure in two weeks if a client is treated with alternate regimens other than the recommended dual therapy of Ceftriaxone 250 mg IM* ***plus*** *Azithromycin 1g.*
**Recommendation: 14 days for NAAT or culture at the site of infection.*

See *CDC's Sexually Transmitted Diseases Treatment Guidelines* for complete treatment recommendations, including guidance on test of cure and treatment regimens for pregnant women.

*CDC's *Sexually Transmitted Diseases Treatment Guidelines, 2015.* http://www.cdc.gov/std/tg2015/tg-2015-print.pdf

Testing Overview

Get the Facts

CDC's website provides STD Fact Sheets in two formats.

Basic Fact Sheets are presented in plain language for individuals with general questions about STDs.

Detailed Fact Sheets are intended for physicians and individuals with specific questions about STDs. Detailed fact sheets include specific testing and treatment recommendations, as well as citations so the reader can research the topic more in depth.

Links to CDC STD Fact Sheets are available in the Additional Resources section of these Procedural Guidelines.

Obtain the Client's Sexual Health History

Additionally, providers must obtain a sexual health history including a genitourinary, sexual and social history to assess the client's risk for CT/GC infection. A sample sexual health history form is provided that can be adapted for use by the provider, or providers may use a document of their own. See Appendix-A

Respect, compassion, a nonjudgmental attitude and assurance of confidentiality are essential to establish rapport with the client to obtain the most comprehensive assessment of the client's risk and needs:

- Assure the client of confidentiality.
- Use open ended questions such as "What has your experience with using condoms been like?"
- Speak at client's level of understanding.
- Ensure that the client understands which infections they are being screened for.
- Be sure the client knows what to expect for the testing they will have.
- Discuss contact information provided for possible follow up for positive tests and discuss who may answer or has access to the phone numbers provided. Also, ask if it is permissible to leave messages on the phone numbers provided.
- Use normalizing language such as "When you have sex, do you have sex with men, women or both?"
- Assure the client that treatment will be provided regardless of client's citizenship, immigration status, language spoken, or lifestyle.

STD Risk Reduction/Education

HIV, STD and Hepatitis brochures are available for free from the DHSS Warehouse. The list of brochures and ordering procedures are available at http://health.mo.gov/warehouse/e-literature.html.

Clients should be provided information about transmission, treatment, and prevention of CT/GC. Providers should educate clients on safer sex behaviors. Prevention messages should be tailored to the client, with consideration given to their specific risk factors for STDs from the sexual health history.

The following suggestions may be useful for clients to reduce the risk of contracting or spreading STDs:

- Abstain from oral, genital, and anal sex.
- Limit sexual contact to a mutually monogamous, uninfected partner.
- Reduce the number of partners.
- Avoid or reduce the number of anonymous partners.
- Use barrier methods for all sexual contact (oral, genital, and anal).
- Abstain from sexual contact with partners who have any type of lesion (oral, anal, or genital) and/or symptoms such as an unusual discharge and/or burning upon urination.
- Be screened annually for STDs, depending on risk behaviors and demographics of client.

Clients with risky sexual and drug-using behaviors are at substantial risk for acquisition of not only STDs, but also HIV. They should be educated on Pre-Exposure Prophylaxis (PrEP) which is a safe and effective HIV prevention tool approved by the FDA. Comprehensive guidelines for the use of daily PrEP can be found at: http://www.cdc.gov/hiv/prevention/research/prep/index.html. The Missouri HIV PrEP Provider Directory can be found by going to www.health.mo.gov/hivprep. If anyone prescribing PrEP would like to be listed on the directory, please contact Lisa Modrusic, Health Educator, at lisa.modrusic@health.mo.gov.

Immunology Test Request form (lab slip)

The Immunology Test Request form (Appendix_B-1) is used as both a data collection instrument and a laboratory requisition form. Data from the form is used for STD Testing Program Quality Assurance evaluation. Data fields on the form must be completed as thoroughly and accurately as possible. **Note: Specimens submitted without a valid Submitter Number internal control number (ICN#) will not be processed by the SPHL.**

The Immunology Test Request form may be completed electronically or manually (hand written/typed) for submission to the SPHL. A copy of the form is available for electronic completion by accessing the SPHL website at: https://webapp01.dhss.mo.gov/LIMSForm_APP/SelectTest.aspx. Instructions for completing the Immunology Test Request form are in Appendix_B-2.

Immunology Test Request Reminders

- An Immunology Test Request form **must** accompany each CT/GC sample submitted to the SPHL. **One form per sample.**
- A ***separate*** Immunology Test Request form **must** accompany all syphilis/HIV specimens submitted to the SPHL.
- One full (6ml) tube of blood is sufficient for both HIV and syphilis testing. If amount of blood is insufficient for both tests, the syphilis testing will be performed first.
- The client name provided on the Immunology Test Request form **must** be identical to the name recorded on the specimen tube or the specimen will be *considered unsatisfactory for testing and will not be tested.* If a name is misspelled or abbreviated, the information on the specimen will be used to identify the client.
- Information is entered at the SPHL exactly as indicated on the Immunology Test Request Form unless noted differently on the specimen. If completing the form manually, *handwriting must be legible* to assure the SPHL staff can process the specimen and capture necessary specimen specific data. Errors must be crossed out and correction written above the error. White-out cannot be used.

- The original Immunology Test Request form will not be returned to the provider. It is recommended that providers keep a copy of the original form in the client chart, should discrepancies with lab submissions occur.

See Frequently Asked Questions (FAQ) regarding the SPHL in Appendix B-3 for additional information.

Electronic Messaging

For those providers with Electronic Medical Records (EMR), test requests and results reports may be sent electronically. Provider systems must have certain requirements to send and receive these messages. For more information, please contact Shondra Johnson, the SPHL LIMS Administrator:

Phone: 573-751-3334
Email: shondra.johnson@health.mo.gov

Specimen Collection Procedures

The STD Testing Program currently uses the APTIMA Unisex Swab Specimen Collection Kit, APTIMA Urine Collection Kit, and APTIMA Multitest Swab Specimen Collection Kit for concurrent testing of CT/GC. Specimens must be collected and handled according to Hologic/GenProbe specifications and recommendations. According to the SPHL Guidelines, reliable laboratory test results require adequate specimen collection, accurate labeling, and transportation to the SPHL **daily or the next working day**. Detailed instructions for specimen collection for each type of test kit are in Appendix B-5.

If the liquid in the collection device spills or is inadvertently disposed of, a new collection device must be used. Do not send a dry swab in the collection device, this is unsatisfactory for testing.

SPHL Specimen Transportation and Courier Information

The SPHL provides a courier service for specimen transportation with 168 pickup locations throughout the State of Missouri. This overnight specimen transportation to the SPHL is provided free of charge to Program providers. For a list of courier location and hours go to:
http://www.health.mo.gov/lab/pdf/courierlocationsbycounty.pdf

- Courier services are provided Monday through Friday, excluding State and Federal Holidays. Specimens transported on Friday will be received and stored for processing the next business day.
- All specimens must be properly packaged in accordance with the Department of Transportation Hazardous Materials Regulations. These regulations can be accessed at: PART 173—SHIPPERS—GENERAL REQUIREMENTS FOR SHIPMENTS AND PACKAGINGS Subpart E—Non-bulk Packaging for Hazardous Materials Other Than Class 1 and Class 7 (§173.199 Category B infectious substances)
- Courier drivers have the right to refuse improperly packaged specimens.
- Specimen transport packaging is available at no charge to the site from the State Public Health Laboratory. Orders can be made by using the Specimen Kit Requisition Form, which is available at: http://health.mo.gov/lab/specimentestforms.php (Appendix B-4) or by calling 573-751-4830
- All specimens must be addressed to or dropped off at the State Public Health Laboratory, 101 North Chestnut St., Jefferson City, Missouri 65101.
- Specimens can be dropped off at any of the designated courier pickup locations.

- Specimens must be at the courier pick-up location 60 minutes before the scheduled pickup time.
- Courier questions should be directed to the SPHL at 573-751-4830.

For guidance on finding which courier location is closest to your location, access the Geographic Information System (GIS) map at https://ogi.oa.mo.gov/DHSS/courierSite/index.html

State Public Health Laboratory Results Report

Testing at the State Public Health Laboratory is performed daily, Monday through Friday except for state and federal holidays. Test results are normally available one to two days after the specimens are received by the SPHL and are mailed back to the submitter once the results are confirmed.

A Laboratory Results Report (Appendix B-6) with the client test results is issued to the agency whose ICN is recorded in the Submitter Number section of the Immunology Test Request form. The Laboratory Results Report **must be date stamped or recorded with the date received by the agency** and maintained in the client's medical record.

If a discrepancy is found regarding a client's demographic information on the Laboratory Result Report and what is written on the Immunology Test Request form, an amended Laboratory Result Report can be obtained from the SPHL, but ***will not*** be generated if the error is linked to illegible handwriting issues. Questions regarding discrepancies on the Laboratory Results Report should be directed to the SPHL at 573-751-3334.

Chlamydia and Gonorrhea

Test Result Follow up

Agencies must have written procedures for the follow-up of clients who test positive for CT/GC and their partners. The medical record must be identified so that necessary staff members recognize that the client requires follow-up. Staff responsible for client and/or partner follow-up should be familiar with the agency's procedures.

There are several important steps to complete immediately after receiving a positive Laboratory Results Report:

- Notify client of result.
- Provide treatment or referral for treatment.
- Assist client with partner follow-up.
- Report required information to DHSS, Bureau of Reportable Disease Informatics (BRDI).

Notify Client of Result

The attending health care provider or other designated staff should attempt to contact the client within one business day of receipt of the Laboratory Results Report. Each attempt to contact the client should be documented in the client's medical record. Documentation should include the date, time, and type of contact performed, and results of the attempted contact.

Initially, a client should be contacted by telephone, when the client has consented to receiving phone calls and telephone contact is within site guidelines. Telephone calls regarding medical test results and/or referrals should be made by the clinician or by staff who have been trained on the proper notification procedures within these guidelines. The following are suggestions when contacting the client by telephone:

- Confirm privacy by using a "first name only" introduction.
- If someone else answers the phone and ask who is calling, please only use your name and not the organization you are calling from.
- Before issuing confidential test results or agency information, verify that the person being addressed is the client by asking specific identifying information (i.e., date of birth, address or other unique identifier established at the time of the client's clinic visit). Do not give confidential information to anyone other than the client.
- Once the individual has been identified as the client, assure they can speak privately at the time and if so, inform them of the test results.
- Stress to the client the need for immediate medical attention and appropriate follow-up including partner referral (if they were not appropriately treated at the initial clinic visit).
- Make an appointment for the client to receive treatment as soon as possible (if applicable) and encourage the client to bring any current sex partners to the clinic visit for testing/treatment. Program expectation is to have no more than 14 days from specimen collection to treatment or referral for treatment.
- If the client is not at home, leave a message asking the client to return your call. Leave your phone number without identifying the agency name.

After three attempts to contact the client by telephone at various times throughout the day with no response or if the client does not have a working telephone, a letter should be mailed to the client (Appendix C-1). Maintenance of confidentiality is paramount.

Provide Treatment or Referral to Treatment

Program expectation is to have no more than 14 days from specimen collection to treatment or referral for treatment. If the client was not treated on the same day as testing, sites should follow up with the client within one business day of the receipt of the laboratory results to discuss treatment options or arrangements. When the client returns for treatment, the attending health care provider should:

- Discuss diagnosis and the client's knowledge about the infection.
- Address client questions.
- Treat according to CDC's *Sexually Transmitted Diseases Treatment Guidelines,* 2015. MMWR, 2015; Vol. 64 No.RR-3 available at http://www.cdc.gov/std/tg2015/tg-2015-print.pdf
- Encourage the client to take all medication as directed and to abstain from sex for seven days after completing treatment and the completion of treatment by partners(s).
- Discuss the importance of referring all of the client's recent sex partners for testing and treatment to reduce the risk of re-infection and further health issues (see partner follow-up).

Assist Client with Partner Follow-up (Partner Services)

Timely treatment of infected individuals and their sex partners is essential to decrease the risk of re-infection and reduce the number of new infections. Currently DHSS does not interview all

positive CT and/or GC clients and perform partner notification due to funding restrictions. Partner follow up is reliant upon the infected client understanding the importance of getting partners treated and sites willing to perform partner notification without any additional funding.

The attending health care provider or other designated staff should:

- Discuss the importance of referring all of the client's recent sex partners for testing and treatment regardless of any signs or symptoms the partner may or may not be experiencing to reduce risk of re-infection.
- Recent sex partners are defined as within the 60 days preceding the onset of the client's symptoms or if asymptomatic, the date of diagnosis through the date of treatment. If the most recent sex partner is reportedly outside the 60-day period, the partner should be referred for testing and treatment.
- Providers should give one Partner Follow-up Referral Card (yellow card) (Appendix C-3) for each at-risk partner identified. Providers should record their facility ICN and date on each card. Contact the STD Testing Program Coordinator at 573-526-3607 to order referral cards.
- Test and presumptively treat any exposed individuals seen at the agency. All partners tested and presumptively treated should be instructed to abstain from sexual activities for seven days after treatment.

*Facility partner follow-up policies/practices may exceed these guidelines in assisting clients to refer their partners for treatment, but at minimum clients should be offered one Partner Follow-up Referral Card for each partner at risk.

Report to Bureau of Reportable Disease Informatics (BRDI)

Chlamydia and gonorrhea are reportable conditions in Missouri and must be reported within three calendar days of the first knowledge or suspicion. Diagnosing providers and laboratories are both required to report.

The Disease Case Report (CD-1) (Appendix C-4) is the statewide reporting form used for reporting all communicable diseases and conditions including chlamydia and gonorrhea. All program providers (agencies) must submit a CD-1 for:

- Positive clients tested at the program provider.
- Positive clients treated at the program provider regardless of where the diagnosis/testing occurred.
- Exposed individuals who receive preventive treatment at the program provider and whose results are positive upon testing.

Subsequent information that may not have been available at the time of initial reporting, such as treatment information, must be added to the CD-1 and resubmitted to BRDI.

Send CD-1s to DHSS Bureau of Reportable Disease Informatics at:

FAX: 573-751-6417
Attention: Bureau of Reportable Disease Informatics

Mail: Missouri Department of Health and Senior Services
Bureau of Reportable Disease Informatics
930 Wildwood Drive, P.O. Box 570
Jefferson City, MO 65109

For more information, visit
http://health.mo.gov/living/healthcondiseases/communicable/communicabledisease/index.php

Syphilis

DHSS Disease Intervention Specialists (DIS) and contracted personnel currently follow-up with clients newly infected with syphilis and their partners statewide (Appendix_C-2). DIS assigned to syphilis cases will contact the testing agency to discuss the infected client and options for notification and treatment. DIS will also provide guidance to the testing agency on the treatment needed for the infected individual (if applicable). Guidance on treatment for syphilis can also be found in CDC's *Sexually Transmitted Diseases Treatment Guidelines,* 2015. MMWR, 2015; Vol. 64 No.RR-3 available at http://www.cdc.gov/std/tg2015/tg-2015-print.pdf

Since syphilis is designated by DHSS as a high-priority infection, DHSS typically receives the result from the State Public Health lab electronically before the testing agency receives the mailed result. In some instances, a DIS is not assigned because the individual is a known previous positive who was treated appropriately and the current testing does not indicate a re-infection (2-dilution rise in titer).

If the testing agency receives a new positive result and a DIS has not been in contact about the results, the testing agency should contact the appropriate DIS or Senior Epidemiology Specialist (SES) in the area within one calendar day of receipt to discuss if follow up is needed (Appendix C-2).

Testing sites are not required to fill out and submit a CD-1 on syphilis cases if the case has been discussed with the DIS or SES.

HIV

DHSS Disease Intervention Specialists (DIS) and contracted personnel currently follow-up with clients newly infected with HIV and their partners statewide (Appendix_C-2). DIS assigned to HIV cases will contact the testing agency to discuss the infected client and options for notification and linkage to care.

Since HIV is designated by DHSS as a high-priority infection, DHSS typically receives the result from the State Public Health lab electronically before the testing agency receives the mailed result.

If the testing agency receives a new positive result and a DIS has not been in contact about the results, the testing agency should contact the appropriate DIS or Senior Epidemiology Specialist (SES) in the area within one calendar day of receipt to discuss if follow up is needed (Appendix C-2).

Testing sites are not required to fill out and submit a CD-1 on HIV cases if the case has been discussed with the DIS or SES.

Send CD-1s to DHSS Bureau of Reportable Disease Informatics at:

FAX: 573-751-6417
Attention: Bureau of Reportable Disease Informatics

Mail: Missouri Department of Health and Senior Services
Bureau of Reportable Disease Informatics
930 Wildwood Drive, P.O. Box 570
Jefferson City, MO 65109

Program Supplies

Test Kits

The following test kits are provided through the STD Testing Program:

Concurrent CT/GC testing kits:
- APTIMA Unisex Swab Specimen Collection Kit
- APTIMA Urine Collection Kit
- APTIMA Multitest Swab Specimen Collection Kit

Red Top serology collection tubes for syphilis and/or HIV testing

Specimen test kits and transport packaging (mailers) are ordered through the SPHL. Orders can be placed using the Specimen Kit Requisition Form, which is available at: http://health.mo.gov/lab/specimentestforms.php, in Appendix B-4 or by calling the SPHL directly at 573-751-4830.

Medication

STD Program medications are to be used for
- Males and females who have a positive test result, regardless of provider.
- Males and females who are known sexual partners to a positive client, regardless of provider.
- Males and females symptomatic of CT/GC.

To order medications, complete the STD Medication Report Order Form (Appendix D-1) and e-mail to STDMEDOrders@health.mo.gov or fax the form to 573-751-6447. Medication orders that do not contain current on-hand inventory counts will **not** be processed. For instructions on completing the STD Medication Report, see Appendix D-2. STD Testing Program provided medications for CT/GC are shipped directly from the DHSS warehouse. Orders are generally shipped within five working days from the receipt of the order, with the exception of Thursday afternoons or Fridays due to the possibility that they may arrive during non-business hours and be left outdoors.

All providers who disburse STD Testing Program funded medications are required to maintain a Record of Drugs form (Appendix D-4). This form must contain a record of all medication disbursements for **three** years prior to the last date of entry. Providers may use their own document or produce a report from electronic records if it contains the same information and can be retrieved for three year period.

Condoms

STD Testing Program condoms can be distributed to any client that is seeking STD testing services or by request. To order condoms, complete the Condom Order Form (Appendix D-3) and e-mail to STDMEDOrders@health.mo.gov or fax the form to 573-751-6447. The STD Testing Program provides youth (classic fit with unique designs appealing to youth), variety (includes flavored and glow-in-the-dark), designer (artistic designs on packaging), standard male condoms, and non-latex male condoms.

The STD Testing Program provided condoms are shipped directly from the DHSS warehouse. Orders are generally shipped within five working days from the receipt of the order, with the exception of Thursday afternoons or Fridays due to the possibility that they may arrive during non-business hours and be left outdoors. Quantities may be limited by DHSS depending on funding and available resources.

Resource Management

Providers should monitor and rotate STD Testing Program provided test kits, condoms, and medications to minimize waste and maximize resources. Sites should contact the STD Testing Program Specialist at 573-751-6129 at least **30 days prior to expiration** for assistance in redistributing test kits, condoms, and medications to other participating STD Testing Program agencies. Medications, condoms, or test kits that expire on site should be disposed of appropriately by the agency. **They should not be returned to DHSS or the SPHL.** On the STD Medication Report (Appendix D-1), document any medication(s) that have expired since the last STD Medication Report submission, including the quantity, expiration date, and disposal date.

Data Analysis and Quality Assurance

Annual Data Analysis

DHSS will conduct, at a minimum, annual data analysis for each facility to determine if appropriate testing practices have been followed. Data evaluated includes positivity rates, out-of-criteria submission and unsatisfactory specimen submission.

Quarterly Data Analysis and Report Cards

DHSS will conduct a quarterly data analysis of test results for each facility to include positive, negative, and indeterminate test results. In addition, DHSS will closely monitor the number of unsatisfactory specimens submitted by each provider and provide follow-up as necessary.

Data is collected and compiled for each facility according to the ICN as submitted to the SPHL on the test request form. This data is compiled to create the STD Testing Program Quarterly Report Card. Providers will receive data specific to their facility each quarter.

Report Card data will be analyzed for:

- **Percent of core data elements complete** – Expectation of at least 90%.
- **Percent of unsatisfactory specimens** – Expectation is less than 2%.
- **Average number of days** from specimen collection to receipt at the SPHL – Expectation is an average of three days or less.
- **Tests submitted** – Total number of specimen submissions sent to the SPHL.
- **Number of out-of-criteria submissions** – Expectation is zero tests.
- **Number and percent positive:** results are based on specimens submitted to the SPHL each quarter.

Facility Assessment Site Visits

DHSS will conduct a Quality Assurance (QA) site visit every three years at minimum. However, additional site visits may be conducted as determined by DHSS (i.e., testing out of criteria, unsatisfactory specimen collection, or use of expired media). Providers will be notified in advance when a site visit is required.

Providers must have appropriate staff available for each site visit, including STD clinic staff and/or the administrator of the site. DHSS staff for each site visit may include the STD Testing Program Coordinator, a regional DHSS DIS, and other DHSS representatives as appropriate.

Assessments will be based upon review of data analysis and other quality assurance measures including:

- Quarterly Report Card data;
- Correct/complete data collection;
- Satisfactory specimen submission to the SPHL;
- Medication and test kit management;
- Submission of CD-1 for positive tests; and
- Treatment or referral for treatment of positive clients within 14 days of specimen collection.

DHSS will notify the appropriate clinic staff in writing of any issues identified during the site visit and the corrective action required.

Sexual Health History Sample Form

REGISTRATION SECTION

DATE

☐ SCREENING (must be CRITERIA ELIGIBLE) ☐ RESCREEN - DATE OF PREVIOUS (+) TEST _____
☐ CONTACT ☐ SYMPTOMATIC _____

LAST NAME	FIRST NAME	TELEPHONE NUMBER	☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ UNKNOWN ☐ SIGNIFICANT OTHER ☐ LIVE IN

ADDRESS	CITY	STATE	ZIP	ETHNICITY ☐ HISPANIC

DATE OF BIRTH	AGE	GENDER ☐ MALE ☐ M2F ☐ FEMALE ☐ F2M	RACE ☐WHITE ☐BLACK/AA ☐ASIAN ☐AI/AN ☐ NH/PI ☐ UNKNOWN ☐ OTHER_____

I hereby grant permission to _____ to obtain specimens to perform tests for Chlamydia, gonorrhea, syphilis, HIV, and other sexually transmitted diseases. I freely accept the medical and laboratory services provided to me. I am fully aware that all positive test results will be confidentially reported to the Missouri Department of Health and Senior Services and, if HIV positive, I will be offered case management services.

PATIENT SIGNATURE	DATE	WITNESS

MEDICAL SECTION

RISK EXPOSURE INFORMATION

NO	YES	
☐	☐	Sex with Male
☐	☐	Sex with Female
☐	☐	Oral Sex
☐	☐	Anal Sex
☐	☐	Trade Sex for Drugs/Money
☐	☐	Alcohol Abuse
☐	☐	IV Drug User
☐	☐	Non-Injecting Drug User
☐	☐	Sex Partner of MSM
☐	☐	Sex Partner of IV Drug User
☐	☐	Sex Partner of PLWH
☐	☐	Victim of Sexual Assault
☐	☐	Occupational Exposure
☐	☐	Other _____
☐	☐	Use condoms/barriers for sex

% of time_____

History:	When/Where	
☐	☐	TB or + Skin Test _____
☐	☐	Hepatitis (type) _____
☐	☐	Hepatitis B Vaccinated

PATIENT HISTORY

Date of last sexual exposure: _____

How many sex partners in last 12 months: _____

NO	YES	
☐	☐	New sex partner last 60 days

NO	YES	
☐	☐	Discharge, duration_____
☐	☐	Dysuria
☐	☐	Abdominal or Groin Pain
☐	☐	Lesion(s)
☐	☐	Rash(es)
☐	☐	Pruritis
☐	☐	Pharyngitis
☐	☐	Lymphadenopathy
☐	☐	Drug Allergy _____
☐	☐	Antibiotics Last 30 days

Reason:_____

☐	☐	Meds currently taking:_____
☐	☐	History of Syphilis: Where:_____ When:_____
☐	☐	History of other STDs:

Female

NO	YES	
☐	☐	History of PID

Date _____

☐	☐	Normal Menstrual History

LMP ____/____/____

☐	☐	Pain with Intercourse
☐	☐	Inter-menstrual bleeding

Contraception:

☐ BCP ☐ Condom
☐ Diaph. ☐ IUD
☐ BTL ☐ None
☐ Foam ☐ Other _____

CLINICAL EXAMINATION

☐ PE ☐ Not Done

NO	YES	
☐	☐	Discharge _____
☐	☐	Cervical Motion Tenderness
☐	☐	Adnexal Tenderness
☐	☐	Lesion(s) _____
☐	☐	Rash(es) _____
☐	☐	Warts
☐	☐	Other _____

LABORATORY

☐ CT/GC Urine

☐ CT/GC Vaginal Swab

CT/GC Unisex Swab
☐ Endocervical
☐ Male Urethral
☐ Pharyngeal
☐ Rectal

☐ Syphilis Serology
☐ HIV Serology ☐ HIV Rapid ☐ HCV Rapid
☐ Wet Prep
☐ KOH_____ ☐ Other_____

HIV INFORMATION

Previously Tested?
☐ No
☐ Unknown
☐ Yes, Positive
☐ Yes, Negative
☐ Yes, Unknown
☐ Date of Test_____

DIAGNOSTICS

Date of Test Result	Type of Test	Qualitative/Quantitative Results

TREATMENT

Medication	Dosage	Date of Treatment

INSTRUCTIONS / FOLLOW-UP

☐ Call _____
☐ RTC _____
☐ Other

SIGNATURES

Examiner_____

Reviewer_____

(Sample Form 12/14, for an editable version please contact the STD Testing Program Coordinator)

Appendix B-1

Immunology Test Request Form

Save | Print | Reset

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
MISSOURI STATE PUBLIC HEALTH LABORATORY
IMMUNOLOGY TEST REQUEST

101 NORTH CHESTNUT STREET, PO BOX 570
JEFFERSON CITY, MO 65101
(573) 751-3334
http://health.mo.gov/lab/index.php

SUBMITTER INFORMATION (RESULTS ARE RETURNED TO THIS ADDRESS)

SUBMITTER NUMBER	FACILITY NAME		
ADDRESS	CITY	STATE	ZIP CODE
OUTSIDE FACILITY NUMBER/NAME	SUBMITTER CONTACT NAME	SUBMITTER TELEPHONE NUMBER	

ATTENDING PHYSICIAN / CLINICIAN INFORMATION

ATTENDING PHYSICIAN/CLINICIAN		TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

PATIENT INFORMATION (REQUIRED)

PATIENT ID (Enter only a patient identifier here)		OUTREACH EVENT	
LAST NAME	FIRST NAME		M.I.
ADDRESS	CITY	STATE	ZIP CODE

GENDER: ☐ Female ☐ Male ☐ M2F ☐ F2M
BIRTH DATE (MM/DD/YYYY)
ETHNICITY: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

RACE: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown

MEDICAL RECORD/CHART ID	MEDICAID NUMBER	PATIENT'S COUNTY OF RESIDENCE

TEST REQUESTED / SPECIMEN TYPE – Check appropriate specimen and fill in requested information

DATE COLLECTED (MM/DD/YYYY)	SPECIMEN ID (LOCAL USE)

SYPHILIS TESTING	HIV TESTING	CHLAMYDIA/GONORRHEA TESTING	
☐ Serum/Blood	☐ Serum/Blood	☐ Endocervical swab	☐ Vaginal swab
☐ CSF (Cerebrospinal fluid)	☐ Plasma	☐ Urethral swab	☐ Rectal swab
		☐ Urine	☐ Pharyngeal swab

PATIENT HISTORY

Syphilis	HIV Rapid Testing
☐ Suspected Latent	☐ Preliminary Positive
☐ Previous Reactive	

Insurance Information - Check only one
☐ Private ☐ Uninsured ☐ Unknown **Public Insurance:** ☐ Medicare ☐ Medicaid ☐ Military ☐ CHIP

Patient Pregnant
☐ Yes ☐ No ☐ Unknown

Chlamydia and Gonorrhea - Check all that apply

Screening Criteria (One test per 12 month period)
- ☐ Female age 15-24 AND ≥ 1 partner (last 12 months)
- ☐ Female age 25-44 AND EITHER New partner (last 60 days) OR ≥ 2 partners (last 12 months)
- ☐ Male with ≥ 1 male sex partner (last 12 months)

Testing Criteria
- ☐ Contact to a CT/GC positive case
- ☐ Rescreen (3-12 months post-treatment only)
- ☐ Signs/Symptoms*

*Defined as mucopurulent cervicitis (MPC), cervicitis, cervical friability, PID suspicion, urethritis

REMARKS

LAB 169 (05/2014)

Note: Immunology Test Request form is subject to change. Please review at least quarterly at:
https://webapp01.dhss.mo.gov/LIMSForm_APP/SelectTest.aspx

Instructions: Immunology Test Request Form Appendix B-2

Each form must be filled out completely and legibly. Please print. Errors must be crossed out and correction written above the error. White-out should not be used. A copy of the form is available for electronic completion by accessing the SPHL website at: https://webapp01.dhss.mo.gov/LIMSForm_APP/SelectTest.aspx.

An Immunology Test Request Form is required for each CT/GC specimen submitted to the SPHL. If submitting syphilis and/or HIV testing for a client also receiving CT/GC testing, providers must complete a separate request form and specifically mark the sections for the syphilis/HIV specimen. Syphilis and HIV testing can be performed from the same specimen sample if there is sufficient volume. If only sending in one tube for syphilis and HIV, please ensure the tube is full.

Submitter Information Section

- **Submitter Number (ICN); Facility Name; Address; City; State; Zip Code:** The ICN is assigned by the SPHL and must be included on each form. If accessing this form electronically from the SPHL website the Submitter Number and the associated demographics fields for Facility Name, Address, City, State and Zip Code will auto-populate. **Submitter Contact Name and Submitter Telephone Number** must be entered manually on the form.
    - **Outside Facility Number/Name:** Use of the Outside Facility Number/Name field is not recommended unless special circumstances exist to warrant results being sent to another facility address, i.e., some providers have satellite sites with limited clinic availability and want results to be sent to the main agency address, which has been assigned a different ICN number. The facility whose ICN number is recorded in the Submitter Number field is the **only** address where results will be sent

NOTE: If there is no Submitter Number listed, the SPHL will try to contact the facility to submit a new request form with their identifying information. If a new request form is not received, the specimen will be considered unsatisfactory for testing and not tested.

Attending Physician/Clinician Information Section

- Record the name of the physician/clinician responsible for oversight of the ordering and/or submitting of the test specimen, along with the physician/clinician demographics of telephone number and full address.

Patient Information Section

- **Patient ID** – Optional field.
- **Outreach Event** – Complete only for **prior authorized** outreach events approved by the STD Testing Program that target designated high risk populations. For approved events, the single word "OUTREACH" must be entered into the field for each outreach event specimen. Outside of this use, this field is to be left blank.
- **Last Name, First Name:** The name on the form **must** be identical to the name on the specimen tube or the specimen will be considered unsatisfactory for testing and not tested.
- **Address, City, State, Zip Code:** Complete fully
- **Gender:** Mark the appropriate gender check box for the patient: F (Female); M (Male); M2F (Male to Female); or F2M (Female to Male).
- **Birth date** – Complete in the format of mm/dd/yyyy (i.e. February 8, 2012 = 02/08/2012). Date of Birth must be recorded on the specimen tube.
- **Ethnicity:** Mark the appropriate check box: Hispanic, non-Hispanic, or Unknown.
- **Race:** Mark the appropriate check box(es): White, Black/African American, Asian, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, Other, or Unknown. (It is acceptable for

the patient to identify more than one race.) *It is recommended that the patient identify the race rather than the health professional assigning a race. For those patients who choose not to identify a race, mark Unknown.*

- **Medical Record Chart ID:** Optional field.
- **Medicaid Number:** Record the patient's Medicaid number (DCN number) if available. The SPHL does not currently collect re-imbursement from other/private insurance providers.
- **Patient's County of Residence:** Record the patient's county of residence.

Test Requested/Specimen Type Section

- **Date Specimen Collected:** Complete in the format of mm/dd/yyyy (i.e. February 8, 2012 = 02/08/2012). Date Specimen Collected must be recorded on the specimen tube.
- **Specimen ID (Local Use):** Optional field.
- **Syphilis Testing:** Mark the appropriate check box: Serum/Blood, or CSF (cerebrospinal fluid).
- **HIV Testing:** Mark the appropriate check box: Serum/Blood, or Plasma.
- **Chlamydia/Gonorrhea Testing:** Mark the appropriate check box: Endocervical swab, Vaginal swab, Urethral swab, Rectal swab, Urine, or Pharyngeal swab.

Patient History

- **Syphilis:** Mark the appropriate check box if applicable: Suspected Latent, or Previous Reactive.
- **HIV Rapid Testing:** Mark the Preliminary Positive box only if applicable. This box only applies to sites performing rapid HIV testing.
- **Insurance Information – Check only one:** Mark the appropriate check box: Private, Uninsured, Unknown, Medicare, Medicaid, Military or CHIP.
- **Patient Pregnant:** Mark appropriate check box; Yes, No, or Unknown.

Chlamydia and Gonorrhea - Check all that apply:

- **Screening Criteria** (One test per 12 month period)
  - Female age 15-24 **AND** ≥ 1 partner (last 12 months)
  - Female age 25-44 **AND Either** New partner (last 60 days) **OR** ≥ 2partners (last 12 months)
  - Male with ≥ 1 male sex partner (last 12 months)
- **Testing Criteria** (Males and Females ≥ 12 years of age)
  - Contact to a CT/GC positive client
  - Rescreen (3-12 month post-treatment only)
  - Signs/Symptoms

Remarks

This area can be used for notes. This information will not be collected or entered into a database or reflected as part of the Laboratory Results Report.

State Public Health Laboratory
Frequently Asked Questions

Where do I get the CT/GC, HIV and/or syphilis test request forms?

- On the internet, go to http://health.mo.gov/lab/index.php. Select **Test Request Forms** from the list Related Links. Select **Test Request Form**. (It is recommended to use Internet Explorer 6.0 or higher and Adobe Reader 9.0 or higher.)
- Select the test being requested.
- Choose your facility from the dropdown list or enter your ICN in the Submitter ID and click Select. This will generate a form already populated with your agency's basic demographic information.
- You can print the form at this point and then complete the required information manually or you may enter all the required information and then print the completed form.
- Put the completed request form with the specimen and return to the SPHL.
- If you do not have access to the Internet, call 573-751-3334 to request a form.

Who do I call if I need collection devices, mailers, or test kits?

- Contact the SPHL Central Services at 573-751-4830.
- Providers may also request supplies by accessing http://health.mo.gov/lab/specimentestforms.php, or by FAX at 573-522-8210.

Can I use a collection device on the day that it expires?

- Yes. If the expiration date on the CT/GC collection device is 3-31-2017, you may use it for specimens collected on 3-31-2017.

A three day weekend is coming up, how should I store my specimens?

- For CT/GC, the specimens can be stored at room temperature or in the refrigerator.
- For HIV and syphilis, if possible, centrifuge the specimen, remove the serum, pour into a transfer tube, and label appropriately.
- If there is no access to centrifuge, store the specimen in the refrigerator at 2°C-8°C.
- Make sure that the specimens are transported with the next courier pick up.

What identifying information should be on the specimen tube?

- Client's first and last name (make sure this matches what is on the test request form), collection date, and date of birth. For CT/GC non-urine specimens, indicate the site of specimen collection (rectum, or pharynx).

What information should be completed on the Immunology Test Request?

- All required fields on the form should be accurately and legibly completed. See instructions in Appendix B-2

Can I submit one tube of blood for HIV and syphilis testing?

Yes.

- Collect enough blood to fill the red top tube.
- Label the tube with client first and last name, date of birth and date specimen collected.
- Complete the Test Request form with Serum/Blood marked under HIV Testing and Syphilis Testing (if both tests are requested), and place in the Immunology mailer (green label) along with specimen.
- Syphilis testing will be performed first.

- CT/GC specimens require a separate form and submit in the orange labeled mail.

How long does it take to receive results back?

- Eight to ten days after receipt of the specimen at the SPHL. Shorter turnaround times, as soon as 48 hours after specimen receipt at SPHL, are likely for sites that submit and receive testing messages electronically.

Will the lab fax immunology test results?

- It is not standard operating procedure to fax test results. This may be done in extreme circumstances, but not on a routine basis. Contact the SPHL with these requests, 573-751-3334.

Appendix B-4

Missouri State Public Health Laboratory
Requisition for Laboratory Specimen Kits

Note: Only the Immunology section applies to the STD Testing Program

Save | Print | Reset | Email

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
STATE PUBLIC HEALTH LABORATORY
REQUISITION FOR LABORATORY SPECIMEN KITS

101 N. CHESTNUT
JEFFERSON CITY, MO 65101
(573) 751-4830
FAX: (573) 522-8210

To obtain information regarding test requisition forms or to find a courier stop for free specimen transport, go to www.health.mo.gov/lab/. Please call (573) 751-4830 if you have any questions. This requisition form can be emailed to labweb1@health.mo.gov

NEWBORN SCREENING

- ☐ Filter Paper - Initial Form (Advanced Payment Required)
- ☐ Filter Paper - Repeat Form (Advanced Payment Required)
- ☐ Envelopes ☐ Courier ☐ Prepaid
- ☐ Listing Pads
- ☐ Labels

MICROBIOLOGY – **Test Request Form Available Online

- ☐ Enteric Kit Complete Kit (For Feces)
- ☐ Enteric (For Feces) Components Only
  ☐ Cary Blair Media
- ☐ Enteric/Special Bacteriology Double Wall Kit (Clinical Labs Only)
  Category B
- ☐ Enteric/Special Bacteriology Category A (e.g. *E. coli* O157:H7)
  Mailing Kit (Clinical Labs Only)
- ☐ Scabies Kit
- ☐ *Bordetella pertussis* Complete Kit (Whooping Cough)
- ☐ *Bordetella pertussis* (Whooping Cough) Components only
  ☐ Media ☐ Saline ☐ Media & Saline
- ☐ Intestinal Parasites Kit
- ☐ Gastrointestinal Outbreak Kit (For Enteric and Norovirus)

CHEMISTRY

- ☐ Blood Lead - Complete Capillary Kit
- ☐ Blood Lead - Capillary Kit Individual Components
  ☐ Device ☐ Sticker ☐ Form ☐ Mailer
- ☐ Blood Lead - Venous Kit
- ☐ Lead Testing ☐ Dust Wipes ☐ Soil Kit ☐ Paint Kit
- ☐ Cubitainers (For Water Collection)

IMMUNOLOGY – **Test Request Form Available Online

- ☐ **YOU MUST BE AN APPROVED SITE**
- ☐ Swab Collection Device for Endocervical, Male Urethral, Rectal, Pharyngeal (Gonorrhea/Chlamydia)
- ☐ Urine Collection Device (Gonorrhea/Chlamydia)
- ☐ Vaginal Swab Collection Device (Gonorrhea/Chlamydia)
- ☐ Gonorrhea/Chlamydia Mailer [1's] [4's] [16's]
- ☐ Syphilis (RPR) and/or HIV Antibody Kit
  [1's] [4's] [16's]

VIROLOGY – **Test Request Form Available Online

- ☐ Virus Isolation Kit
- ☐ Virus Isolation Kit - Rash Kit (Unknown Rash)
- ☐ Virus Isolation Kit - Seasonal Influenza Surveillance Kit
- ☐ Virus Isolation Kit - Respiratory (Avian Flu)
- ☐ Virus Isolation Kit - Mumps
- ☐ Hepatitis Screening Kit [1's] [4's]
- ☐ Viral Serology Kit
  (Measles, Rubella, Arbovirus, Rickettsial, West Nile)

TUBERCULOSIS – **Test Request Form Available Online

- ☐ AFB for Clinical Specimens (Category B mailer)
- ☐ AFB Reference Culture (Category A mailer)

ENVIRONMENTAL

- ☐ Private Drinking Water Kit (For Bacteria)
- ☐ Private Drinking Water Forms Personalized (LPHA Use)
- ☐ Private Drinking Water Forms Blank (For Distribution)
- ☐ Recreational Water Kit
- ☐ Public Drinking Water Information:
  http://www.health.mo.gov/lab/specimentestforms.php

CONTACT NAME | TELEPHONE NUMBER

FACILITY NAME

ADDRESS (STREET, CITY, ZIP CODE) (STREET ADDRESS REQUIRED FOR UPS DELIVERY)

LAB USE ONLY

DATE ORDER RECEIVED

DATE ORDER SHIPPED

Appendix B-5

Specimen Collection Procedure Instructions

Procedure for Endocervical Swab Specimen Collection

- Remove excess mucus from cervical os and surrounding mucosa using cleaning swab (white shaft swab in package with red printing). **Discard this swab**. **Note:** To remove excess mucus from the cervical os, a large-tipped swab (not provided) may be used.
- Insert specimen collection swab (blue shaft swab in package with green printing) into endocervical canal.
- Gently rotate swab clockwise for 10 to 30 seconds in endocervical canal to ensure adequate sampling.
- Withdraw swab carefully; avoid any contact with vaginal mucosa.
- Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the transport tube.
- Carefully break swab shaft at score line; use care to avoid splashing contents.
- Re-cap swab specimen transport tube tightly.
- Label tube legibly with name, date of birth, and specimen collection date. A permanent black marker is the preferred method, but a label is acceptable. Assure the label is securely placed on the tube to avoid it sticking to other objects.
- After collection, transport and store the swab specimen transport tube at 2°C to 30°C until transported to SPHL. Specimens must be assayed within 60 days of collection. **However, since an older specimen is not as viable as a fresh specimen, please transport specimens to the SPHL on a daily schedule.**

  The sequence of Pap testing in relation to other cervicovaginal specimens does not appear to influence Pap test results or their interpretation. Therefore, when other cultures or specimens are collected for STD diagnoses, the Pap test can be obtained last.[1]

Procedure for Vaginal Swab Specimen Collection (Self Collection)

- Partially peel open swab package. Do not touch soft tip or lay swab down. *If soft tip is touched, swab is laid down, or swab is dropped, request a new APTIMA Vaginal Swab Specimen Collection Kit.*
- Remove swab.
- Hold swab by placing thumb and forefinger in the middle of the swab shaft.
- Carefully insert swab into the inside opening of the vagina, about two (2) inches and gently rotate swab for 10 to 30 seconds. Make sure swab touches the walls of the vagina so that moisture is absorbed by swab.
- Withdraw swab without touching skin.
- While holding swab in same hand, unscrew the tube cap. Do not spill tube contents. *If tube contents are spilled, request a new APTIMA Vaginal Swab Specimen Collection Kit.*
- Immediately place swab into transport tube so that the tip of the swab is visible below tube label.
- Carefully break swab shaft at the score line against the side of the tube.
- Tightly screw cap onto tube.
- Label tube legibly with name, date of birth, and specimen collection date. A permanent black marker is the preferred method, but a label is acceptable. Assure the label is securely placed on the tube to avoid it sticking to other objects.

---

[1] CDC's *Sexually Transmitted Diseases Treatment Guidelines,* 2015. MMWR, 2015; Vol. 64 No.RR-3

- After collection, transport and store the swab specimen transport tube at 2°C to 30°C until transported to SPHL. Specimens must be assayed within 60 days of collection. **However, since an older specimen is not as viable as a fresh specimen, please transport specimens to the SPHL on a daily schedule.**

Procedure for Male Urethral Swab Specimen Collection

Client should not have urinated for at least one hour prior to specimen collection.

- Insert specimen collection swab (blue shaft swab in package with green printing) 2 to 4 cm into urethra.
- Gently rotate swab clockwise for 2 to 3 seconds in urethra to ensure adequate sampling.
- Withdraw swab carefully.
- Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the specimen transport tube.
- Carefully break swab shaft at score line; use care to avoid splashing contents.
- Re-cap swab specimen transport tube tightly.
- Label tube legibly with name, date of birth, and specimen collection date. A permanent black marker is the preferred method, but a label is acceptable. Assure the label is securely placed on the tube to avoid it sticking to other objects.
- After collection, transport and store the swab specimen transport tube at 2°C to 30°C until tested. Specimens must be assayed within 60 days of collection. **However, since an older specimen is not as viable as a fresh specimen, please transport specimens to the SPHL on a daily schedule.**

Procedure for Urine Specimen Collection

Client should not have urinated for at least one hour prior to specimen collection.

- Direct client to provide first-catch urine (approximately 20 to 30 ml of initial urine stream) into urine collection cup free of any preservatives. Collection of larger volumes of urine may result in specimen dilution that may reduce test sensitivity. Female clients should not cleanse labial area prior to providing specimen.
- Urine samples must be transferred into the urine specimen transport tube within 24 hours of collection.
- Remove cap from urine specimen transport tube and transfer 2 ml of urine into urine specimen transport tube using the disposable pipette (provided). The correct volume of urine has been added when the fluid level is between the black fill lines on the urine specimen transport tube label.
- Re-cap urine specimen transport tube tightly. This is now known as the "processed urine specimen."
- Label tube legibly with name, date of birth, and specimen collection date. A permanent black marker is the preferred method, but a label is acceptable. Assure the label is securely placed on the tube to avoid sticking to other objects.
- After collection, transport and store the urine specimen transport tube at 2°C to 30°C until transported to SPHL. Processed urine specimens should be assayed with the APTIMA Combo 2 Assay within 30 days of collection. **However, since an older specimen is not as viable as a fresh specimen, please transport specimens to the SPHL on a daily schedule.**

Procedure for Rectal and Pharyngeal (extragenital) Specimen Collection

During 2011, a verification study was performed by the SPHL for rectal and pharyngeal specimen collection using the APTIMA Unisex Swab Specimen Collection Kit. The collection devices are not currently FDA approved for extragenital testing. However, the validation study indicated that using the test kits for CT/GC collection was acceptable and is therefore currently being used at the SPHL.

Rectal Specimens

- Use the APTIMA Unisex Swab Specimen Collection Kit.
- Discard the white shaft cleaning swab.
- Insert the specimen collection swab (blue shaft) into the anal canal.
- Rotate for 15-30 seconds.
- Withdraw the swab carefully.
- Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the specimen transport tube.
- Carefully break the swab shaft at the score line; avoid splashing the contents.
- Recap the swab specimen transport tube tightly.
- Make sure specimen is labeled with client's first and last name, date of birth, date of collection, and "rectal".
- After collection, transport and store the swab specimen transport tube at 2°C to 30°C until transported to SPHL. Specimens must be assayed within 60 days of collection. **However, since an older specimen is not as viable as a fresh specimen, please transport specimens to the SPHL on a daily schedule.**

Pharyngeal Specimens

- Use the APTIMA Unisex Swab Specimen Collection Kit.
- Discard the white shaft cleaning swab.
- Instruct client to tilt head backwards, open mouth, and say "ah". A tongue depressor may be used to depress the tongue and facilitate the visualization of pharynx.
- Insert the specimen collection swab (blue shaft) without touching lips, teeth, tongue, or cheeks.
- Gently and quickly, swab the tonsillar area side to side, making contact with inflamed or purulent sites.
- Withdraw the swab carefully.
- Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the specimen transport tube.
- Carefully break the swab shaft at the score line; avoid splashing the contents.
- Recap the swab specimen transport tube tightly.
- Make sure specimen is labeled with client's first and last name, date of birth, date of collection, and "pharyngeal".
- After collection, transport and store the swab specimen transport tube at 2°C to 30°C until transported to SPHL. Specimens must be assayed within 60 days of collection. **However, since an older specimen is not as viable as a fresh specimen, please transport specimens to the SPHL on a daily schedule.**

SAMPLE

Missouri Department of Health & Senior Services
State Public Health Laboratory
101 N. Chestnut
PO Box 570
Jefferson City, MO 65102
http://www.health.mo.gov/lab/index.php
Bill Whitmar, Laboratory Director

LABORATORY RESULTS REPORT
Date Generated: Mar 26, 2014
Page 1 of 1

Submitter Information	Patient Information		Specimen Information	
1656 - BUREAU OF STD/HIV	SAMPLE, TEST		Accession Number:	2014000041
930 WILDWOOD	1256 ANY STREET		Collection Date:	03/25/2014
JEFFERSON CITY, MO 65109	ANY CITY, MO 12345		Received Date:	03/26/2014
	ID:		Specimen ID:	
	County:	ANY COUNTY	Source :	
	Date of Birth:	01/02/1999	Other :	
	Gender:	M	Type :	URINE
Clinician Information	Med Rec/Chart #:	123456789	Outbreak/Event Name:	
DOCTOR, MY				

TEST NAME	RESULT		REPORTED
CHLAMYDIA/GONORRHEA NUCLEIC ACID AMPLIFICATION	CHLAMYDIA TRACHOMATIS:	POSITIVE	03/26/2014
	CHLAMYDIA INTERPRETATION:	rRNA DETECTED	
	NEISSERIA GONORRHOEAE:	NEGATIVE	
	GONORRHOEAE INTERPRETATION:	rRNA NOT DETECTED	

TRAILER

CHLAMYDIA/GONORRHEA NUCLEIC ACID AMPLIFICATION - THIS TEST INDICATES THE PRESENCE OR ABSENCE OF CHLAMYDIA TRACHOMATIS AND/OR NEISSERIA GONORRHOEAE RIBOSOMAL RNA. THE RESULTS SHOULD BE CONSIDERED IN CONJUNCTION WITH CLINICAL INFORMATION AND/OR ADDITIONAL TESTS. CLINICAL DIAGNOSIS AND THERAPY SHOULD NOT BE BASED SOLELY ON THE RESULTS OF THE LABORATORY TESTS. THE PERFORMANCE OF THIS TEST HAS NOT BEEN EVALUATED IN ADOLESCENTS LESS THAN 14 YEARS OF AGE.

Interpretation of Nucleic Acid Amplification Test (NAAT)

Endocervical, urethral, urine, vaginal swab, rectal, and pharyngeal samples are screened by a nucleic acid amplification test (NAAT) that utilizes target capture for in vitro qualitative detection and differentiation of ribosomal RNA (rRNA) from chlamydia trachomatis and/or Neisseria gonorrhoeae. Upon completion of testing, the results will be mailed to the submitter.

- **Positive** = rRNA detected
- **Negative** = No rRNA detected
- **Unsatisfactory** = Specimen not usable (i.e. expired media, no swab, wrong swab, specimen labeling error, etc.) Submit another sample if client has not been prophylactically treated.
- **Indeterminate** = Test was inconclusive. Submit another sample if client has not been prophylactically treated.

SAMPLE

Missouri Department of Health & Senior Services
State Public Health Laboratory
101 N. Chestnut
PO Box 570
Jefferson City, MO 65102
http://www.health.mo.gov/lab/index.php
Bill Whitmar, Laboratory Director

LABORATORY RESULTS REPORT

Date Generated: Apr 8, 2014

Submitter Information
1656 - BUREAU OF STD/HIV
930 WILDWOOD
JEFFERSON CITY, MO 65109

Clinician Information
DOCTOR, MY

Patient Information
SAMPLE, TEST
1256 ANY STREET
ANY CITY, MO 12345

ID:
County: ANY COUNTY
Date of Birth: 01/02/1999
Gender: F
Med Rec/Chart #: 123456789

Specimen Information
Accession Number: 2014000055
Collection Date: 04/07/2014
Received Date: 04/08/2014
Specimen ID:
Source :
Other :
Type : SERUM/BLOOD
Outbreak/Event Name:

TEST NAME		RESULT	REPORTED
HIV AG/ AB COMBO	CMIA:	NON-REACTIVE	04/08/2014
	INTERPRETATION:	HIV-1 p24 ANTIGEN AND HIV-1 / HIV-2 ANTIBODIES NOT DETECTED	
RPR	RPR:	NON-REACTIVE	04/08/2014

TRAILER

HIV AG/ AB COMBO - THE CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNASSAY) IS A SCREENING TEST FOR HIV ANTIGEN AND ANTIBODIES. A REACTIVE RESULT DOES NOT DISTINGUISH BETWEEN THE DETECTION OF HIV-1 p24 ANTIGEN, HIV-1 ANTIBODY, OR HIV-2 ANTIBODY. THIS TEST IS TO BE USED AS AN AID IN THE DIAGNOSIS OF HIV-1 / HIV-2 INFECTION, INCLUDING ACUTE OR PRIMARY HIV-1 INFECTION.

RPR - THE RPR (RAPID PLASMA REAGIN) IS A QUALITATIVE TEST USED TO SCREEN SERUM FOR SYPHILIS. ALL SPECIMENS THAT REACT WILL BE TESTED BY THE RPR QUANTITATIVE PROCEDURE AND A TITER (HIGHEST DILUTION THAT YIELDS A POSITIVE READING) WILL BE REPORTED. ALL SPECIMENS PRODUCING A REACTIVE RPR RESULT WILL BE FURTHER TESTED BY THE TP-PA (TREPONEMA PALLIDUM-PARTICLE AGGLUTINATION). REQUESTS FOR TP-PA TESTING ON SPECIMENS THAT ARE NON-REACTIVE BY THE RPR TEST WILL NOT BE HONORED UNLESS THE PHYSICIAN STATES ON THE TEST REQUEST FORM THAT LATE SYPHILIS IS SUSPECTED.

Appendix B-7

Interpretation of HIV State Public Health Lab Test Results

Blood, serum, and plasma samples will be screened by a chemiluminescent microparticle immunoassay test (CMIA) for the qualitative detection of HIV-1 p24 antigen, and antibodies to HIV-1 and/or HIV-2. Any repeatedly reactive CMIA sample will be confirmed with a Geenius test that detects and identifies antibodies to HIV Type 1 (HIV-1) and HIV Type 2 (HIV-2). All specimens with Geenius nonreactive or HIV-1 indeterminate results will be sent to Wadsworth Center for HIV Nucleic Acid Testing (NAT) if the specimen requirements are met (greater than 700 µl of serum present and specimen is less than three days old). The trailer on the lab results report (B-6) will indicate if the specimen was sent for further testing or if another specimen should be submitted (if applicable).

Upon completion of testing, the results will be mailed to the submitter. If the sample was sent out for more supplementary testing, a separate report will be sent containing those results.

Test 1	Test 2	Test 3		
CMIA*	**Geenius**	**HIV-1 NAAT****	**Interpretation**	**Further Action**
Nonreactive	N/A	N/A	HIV-1 p24 antigen and HIV-1/HIV-2 antibodies not detected.	Sample can be reported as nonreactive for HIV. If recent HIV exposure is suspected, redraw and repeat algorithm. If acute HIV infection is suspected, consider testing for HIV-1 RNA.
Reactive	HIV-1 Positive	N/A	Positive for HIV-1 antibodies. Laboratory evidence consistent with established HIV-1 infection is present.	Provide person tested with appropriate counseling and link to medical care.
Reactive	HIV-2 Positive	N/A	Positive for HIV-2 antibodies. Laboratory evidence of HIV-2 infection is present.	Provide person tested with appropriate counseling and link to medical care.
Reactive	HIV Positive (Undifferentiated)	N/A	Positive for HIV antibodies. Laboratory evidence of HIV infection is present. HIV antibodies could not be differentiated as HIV-1 or HIV-2.	Provide person tested with appropriate counseling and link to medical care and treatment. Additional testing for HIV-1 RNA and HIV-2 RNA should be performed if clinically indicated.
Reactive	Nonreactive or HIV-1 Indeterminate	Detected	Positive for HIV-1. Laboratory evidence of HIV-1 infection consistent with an acute or early HIV-1 infection.	Provide person tested with appropriate counseling and link to medical care and treatment.
Reactive	Nonreactive or HIV-1 Indeterminate	Not Detected	HIV antibodies were not confirmed and HIV-1 RNA was not detected. No laboratory evidence of HIV infection.	Consider repeat testing if clinically indicated. If there is a reason to suspect recent HIV-2 infection, additional testing for HIV-2 RNA or DNA should be considered.
Reactive	Nonreactive or HIV-1 Indeterminate	Invalid or Not Performed	HIV antibodies not confirmed and HIV-1 RNA testing was not performed.	Testing of this specimen is incomplete. Follow-up testing for HIV antibodies and HIV-1 RNA is recommended as soon as possible.

* The 2nd and 3rd CMIAs are performed the same day following the initial reactive CMIA.

**All specimens with Geenius nonreactive or HIV-1 indeterminate results will be sent to Wadsworth Center for HIV NAT if the specimen requirements are met (greater than 700 µl of serum present and specimen is less than 3 days old).

Interpretation of Syphilis Rapid Plasma Reagin (RPR) Test

Blood and serum samples will be screened by an RPR test that uses charcoal agglutination for detection of reagin antibodies. Reagin antibodies are non-treponemal antibodies produced by the body's defense mechanism in response to an infection with *Treponema pallidum*. If the RPR is reactive, a quantitative titer (measures the level of antibody) and a *Treponema pallidum* particle agglutination assay (TP-PA) will be done. Upon completion of testing, the results will be mailed to the submitter.

- **Reactive:** Non-Treponemal Antibodies detected. An RPR Titer and TP-PA will be performed.
- **Non-Reactive:** Non-Treponemal Antibodies not detected. Cannot rule out early infection.
- **Unsatisfactory:** Specimen not usable (i.e. specimen labeling error, in transit too long, quantity not sufficient, hemolyzed, etc.). Submit another sample.

Interpretation of Syphilis TP-PA Test

- **Reactive:** Past or present syphilis infection.
- **Non-Reactive:** No past or present infection but cannot rule out early infection.
- **Indeterminate:** Submit another sample in two weeks or confirm by other methods such as an enzyme immunoassay (EIA) or a fluorescent treponemal antibody-absorption test (FTA-ABS).

Appendix C-1

Sample Client Follow-up Letter

(Use facility letterhead)

Date

Dear:

It is important that you contact this office immediately by calling (000) 000-0000.

We need to discuss your recent visit with us.

Sincerely,

Agency Name

Appendix C-2

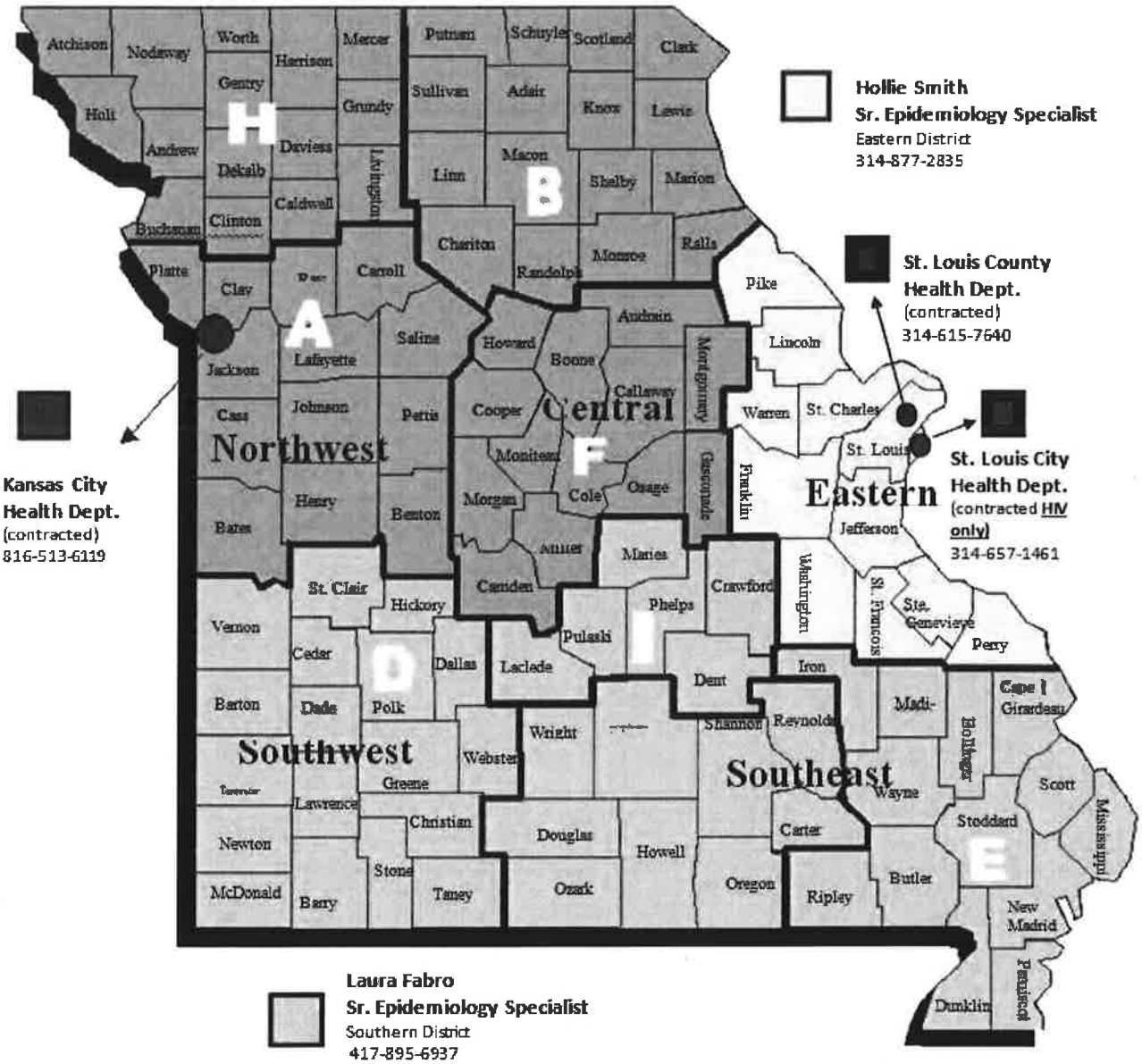
Disease Intervention Specialist Contact Map

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
Bureau of HIV, STD, and Hepatitis
STD/HIV Partner Services Program
2017

Craig Highfill,
Director of Prevention
314-877-0245
Cell phone 314-452-4709
Craig.Highfill@health.mo.gov

Tichelle Dougan
DIS Program Coordinator
573-526-4977
Cell phone 573-508-9909
Tichelle.Dougan@health.mo.gov

Leslie Whitson,
Sr. Epidemiology Specialist
Northern District
816-350-5414
Leslie.Whitson@health.mo.gov



Hollie Smith
Sr. Epidemiology Specialist
Eastern District
314-877-2835

St. Louis County Health Dept.
(contracted)
314-615-7640

St. Louis City Health Dept.
(contracted HIV only)
314-657-1461

Kansas City Health Dept.
(contracted)
816-513-6119

Laura Fabro
Sr. Epidemiology Specialist
Southern District
417-895-6937
Laura.Fabro@health.mo.gov

Revised December 2017

Appendix C-3

Partner Follow-up Referral Card (Yellow Card)

Outside

Date:_____ Agency ICN:_____

Missouri Department of Health and Senior Services
Bureau of HIV, STD, and Hepatitis

Show this card to the doctor or nurse so you can receive the appropriate tests and/or treatment.

If you have questions, call your local county or city health department.

For more information on STDs and HIV please visit: www.cdc.gov

You have been exposed to Chlamydia Gonorrhea. These are sexually transmitted diseases that can cause serious complications.

Even if you do not have any signs or symptoms, you need testing/examination and/or treatment. Go to your county health department, public health facility, or your private medical doctor **as soon as possible.**

Inside

Dear Provider:
The person presenting this card has been exposed to (circle all that apply)
Chlamydia Gonorrhea
It is recommended that he/she be examined, tested, and treated today.

Chlamydia Treatment (Uncomplicated in Adults/Adolescents)
Infections of the: Cervix, Pharynx, Urethra, and Rectum

- Azithromycin 1 g orally in a single dose

OR

- Doxycycline 100 mg orally BID for 7 days

For treatment and follow up recommendations for pregnant women and children, please see the 2015 CDC Treatment Guidelines at http://www.cdc.gov/std/tg2015/.

Gonorrhea Treatment (Uncomplicated in Adults/Adolescents)
Infections of the: Cervix, Urethra, and Rectum

- Azithromycin 1 g orally in a single dose

PLUS

- Ceftriaxone 250 mg as a single intramuscular dose

If cephalosporin allergy:

- Gentamicin 240 mg in a single intramuscular dose

PLUS

- Azithromycin 2 g orally in a single dose

For other treatment and follow up recommendations for children, pharyngeal gonorrhea, pregnant women and those with cephalosporin allergy, please see the 2015 CDC Treatment Guidelines at http://www.cdc.gov/std/tg2015/.

Appendix C-4

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
Section for Disease Prevention
930 Wildwood Drive, P.O. Box 570, Jefferson City, MO 65102-0570
Telephone: (573) 751-6113 FAX: (573) 526-0235

DISEASE CASE REPORT

IF THE CONDITION REQUIRES IMMEDIATE PUBLIC HEALTH INTERVENTION, OR IS SUSPECTED OF BEING A DELIBERATE ACT, OR PART OF AN OUTBREAK, CALL THE DEPT OF HEALTH AND SENIOR SERVICES 24 HOURS A DAY, 7 DAYS A WEEK AT 1-800-392-0272

FOR PUBLIC HEALTH AGENCY USE ONLY	
CONDITION I.D.	PARTY I.D.
OUTBREAK I.D.	DATE RECEIVED BY LPHA
JURISDICTION	

Patient Information

NAME (LAST, FIRST, M.I.)	PATIENT IDENTIFIER	DATE OF BIRTH	AGE	MARITAL STATUS	SEX
					☐ Male ☐ Female

PATIENT'S COUNTRY OF ORIGIN	DATE ARRIVED IN USA	OCCUPATION	RACE/ETHNICITY (CHECK ALL THAT APPLY)
			☐ AMERICAN INDIAN ☐ PACIFIC ISLANDER ☐ UNKNOWN ☐ ASIAN ☐ WHITE ☐ BLACK ☐ OTHER RACE – Specify: HISPANIC: ☐ YES ☐ NO ☐ UNK
HOME TELEPHONE	WORK TELEPHONE	PARENT OR GUARDIAN	

IS PERSON HOMELESS? ☐ YES	ADDRESS	CITY, STATE, ZIP CODE	COUNTY OF RESIDENCE

WAS PATIENT HOSPITALIZED? ☐ YES ☐ NO	IF YES, NAME OF HOSPITAL	HOSPITAL ADDRESS	CITY, STATE, ZIP CODE	HOSPITAL TELEPHONE

Reporter

REPORTER NAME (Form Completed By)	REPORTING FACILITY	REPORTER ADDRESS	CITY, STATE, ZIP CODE	REPORTER TELEPHONE

TYPE OF REPORTING FACILITY	DATE OF REPORT	PHYSICIAN/CLINIC NAME	PHYSICIAN/CLINIC TELEPHONE	HAS PATIENT BEEN NOTIFIED OF DIAGNOSIS/LAB RESULTS?
☐ PHYSICIAN ☐ OUTPATIENT CLINIC ☐ HOSPITAL ☐ LABORATORY		PHYSICIAN/CLINIC ADDRESS	CITY, STATE, ZIP CODE	☐ YES ☐ NO ☐ UNK

Risk/Background Information

PREGNANT ☐ YES - DUE DATE: ☐ NO ☐ UNK	OTHER ASSOCIATED CASES? ☐ YES ☐ NO ☐ UNK	☐ YES ☐ NO ☐ UNK	RECENT TRAVEL OUTSIDE OF IMMEDIATE AREA? DATE OF DEPARTURE	DATE OF RETURN	TRAVEL LOCATION

CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):	PATIENT YES	PATIENT NO	PATIENT UNK	HHLD MEMBER YES	HHLD MEMBER NO	HHLD MEMBER UNK	IF YES, PROVIDE BUSINESS NAME, ADDRESS AND TELEPHONE NUMBER
IS A FOOD HANDLER?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR ATTENDS CHILD/ ADULT CARE CENTER?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR RESIDENT OF NURSING HOME?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR INMATE OF CORRECTIONAL FACILITY?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH HOMELESS SHELTER?	☐	☐	☐	☐	☐	☐	
IS A STUDENT OR FACULTY/STAFF OF A SCHOOL?	☐	☐	☐	☐	☐	☐	
IS A HEALTH CARE WORKER?	☐	☐	☐	☐	☐	☐	
OTHER (specify):	☐	☐	☐	☐	☐	☐	
HAS PATIENT DONATED OR RECEIVED BLOOD OR TISSUE?	☐	☐	☐	DATE DONATED	DATE RECEIVED		SPECIFY TYPE OF BLOOD OR TISSUE AND FACILITY NAME/ADDRESS

Disease

DISEASE/CONDITION NAME(S)	ONSET DATE(S)	DIAGNOSIS DATE(S)	SEVERITY OF VARICELLA	VACCINATION HISTORY FOR REPORTED CONDITION DATES ☐ UNKNOWN
			☐ <50 lesions ☐ 50-249 lesions ☐ 250-500 lesions	

Symptoms

SYMPTOM	SYMPTOM SITE	ONSET DATE (MO/DAY/YR)	DURATION (DAYS)

DID PATIENT DIE OF THIS ILLNESS? ☐ YES ☐ NO - IF YES, GIVE DATE:

COMMENTS:

Diagnostics

DO NOT COMPLETE DIAGNOSTICS IF LAB SLIP IS ATTACHED

RESULT DATE (MO DAY YR)	TYPE OF TEST	SPECIMEN TYPE SOURCE	SPECIMEN DATE (MO/DAY/YR)	QUALITATIVE/QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME/ADDRESS (STREET, or RFD, CITY, STATE, ZIP CODE)	LIVER FUNCTION RESULTS
							ALT
							AST

Treatment Information

TYPE OF TREATMENT (MEDS) IF NOT TREATED, REASON	DOSAGE	TREATMENT START DATE (MO/DAY/YR)	TREATMENT END DATE (MO/DAY/YR)	TREATMENT DURATION (IN DAYS)	PREVIOUS MEDICATIONS USED FOR TREATMENT	PREVIOUS TREATMENT FACILITY	TELEPHONE NUMBER

Highlighted areas of the form are reportable to CDC and must be filled out accurately and legibly for each positive CT/GC/syphilis/HIV client. Electronic version available at:
http://health.mo.gov/living/healthcondiseases/communicable/communicabledisease/index.php

Appendix D-1

STD Medication Report

Instructions: Please complete the following form with each medication order and fax or email it the HIV/STD Testing Program Coordinator. The fax number is 573-751-6447. The email is STDMEDOrders@health.mo.gov.

Date	
Name of Person Ordering Medications	
Name of Agency Ordering Medications	
Street Address	
City, State, Zip Code	
Phone Number with Area Code	

Medication Order (UD=Unit Dose tablet or capsule)	Check type of medication and enter the number of boxes. Note: only full boxes can be shipped except for Bicillin LA
Azithromycin 250 mg -(1 Box = 50 UD)	☐Azithromycin # of boxes
Ceftriaxone 250 mg -(1Box= 10 vials)	☐Ceftriaxone # of boxes
Lidocaine 1%-(1 Box=10 Ampules)	☐Lidocaine # of boxes
Doxycycline 100 mg-(1 Box = 30 UD)	☐Doxycycline # of boxes
Gentamicin 80 mg-(1 Box = 25 vials)	☐Gentamicin # of boxes
Bicillin LA 2.4 MU -(Box=10 Syringes)	☐Bicillin L-A # of syringes

Expired Medication	**Quantity**	**Packaged Unit**	**Expiration Date**	**Disposal Date**
Azithromycin 250 mg-(1 Box = 50 UD)		UD		
Ceftriaxone 250 mg-(1Box= 10 vials)		Vials		
Lidocaine 1%-(1 Box=10 Ampules)		Ampules		
Doxycycline 100 mg-(1 Box = 30 UD)		UD		
Gentamicin 80 mg-(1 Box = 25 vials)		Vials		
Bicillin LA 2.4 MU-(Box=10 Syringes)		Syringes		

Medication On Hand (Complete for all meds with each Medication Order)	**Quantity**	**Packaged Unit**	**Expiration Date**
Azithromycin 250 mg-(1 Box = 50 UD)		UD	
Ceftriaxone 250 mg-(1Box= 10 vials)		Vials	
Lidocaine 1%-(1 Box=10 Ampules)		Ampules	
Doxycycline 100 mg-(1 Box = 30 UD)		UD	
Gentamicin 80 mg-(1 Box = 25 vials)		Vials	
Bicillin LA 2.4 MU-(Box=10 Syringes)		Syringes	

Medication Redistributed	**Quantity**	**Packaged Unit**	**Expiration Date/Receiving Site**
Azithromycin 250 mg-(1 Box = 50 UD)		UD	
Ceftriaxone 250 mg-(1Box= 10 vials)		Vials	
Lidocaine 1%-(1 Box=10 Ampules)		Ampules	
Doxycycline 100 mg-(1 Box = 30 UD)		UD	
Gentamicin 80 mg-(1 Box = 25 vials)		Vials	
Bicillin LA 2.4 MU-(Box=10 Syringes)		Syringes	

Appendix D-2

STD Medication Report Instructions

Agency Information
Complete all fields

Medication ordering
Check each medication requested and the number of **boxes** ordered. **Note**: Only full boxes can be shipped, except for Bicillin LA. **Medication on Hand** section must be completed with each Medication reorder. Medications can be ordered as needed.

Supply of Gentamicin and Doxycycline is limited. These medications may only be ordered for **current** cases that meet the specified criteria. If a case occurs, please contact your regional DIS.

Expired Medication
Complete this section for any medication(s) that have expired since the last STD Medication Report submission, including the quantity, expiration date, and disposal date. Record by number of unit dose (UD) tablets/capsules, vials, ampules or syringes.

Contact the HIV/STD Testing Program Specialist at 573-751-6129 at least 30 days prior to expiration of medication(s) for assistance in redistributing medication if needed. Medications that expire on site should be disposed of by the agency. **They should not be returned to DHSS or SPHL.**

Medication on Hand
Record all medication(s) currently on hand, including quantity and expiration date ***each time medication is re-ordered.*** Record by number of UD tablets/capsules, vials, ampules or syringes.

Medication Redistributed
Complete this section for medication(s) redistributed since the last STD Medication Report submission, including the quantity, expiration date, and the receiving site. Record by number of UD tablets/capsules, vials, ampules or syringes.

Appendix D-3

Condom Order Form

Instructions: Please complete this form and e-mail or fax to:

ATTN: HIV/STD Testing Program Specialist
Missouri Department of Health and Senior Services
930 Wildwood, PO Box 570
Jefferson City, MO 65102
Phone (573) 751-6129
Fax (573) 751-6447
STDMEDOrders@health.mo.gov

Name of person ordering	
Name of agency	
Street Address	
City, State, Zip	
Phone Number	
Email Address	
Date	

Check which condoms your site is ordering and write the amount being ordered.	☐	**Youth/Urban** - One® Brand male condoms (100 per bag)	_____ Bag(s)
	☐	**Vanish/Sensitive** - One® Brand male condoms (100 per bag)	_____ Bag(s)
	☐	**Glow-in-the-Dark** - One® Brand male condoms (100 per bag)	_____ Bag(s)
	☐	**Ribbed** – B Holding male condoms (100 per bag)	_____ Bag(s)
	☐	**Strawberry flavor** – B Holding male condoms (100 per bag)	_____ Bag(s)
	☐	**Extra Large** – B Holding male condoms (100 per bag)	_____ Bag(s)
	☐	**Standard** - B Holding male condoms (100 per bag)	_____ Bag(s)
	☐	**Variety/Mixed** - (100 per bag)	_____ Bag(s)
	☐	**Non-Latex** male condoms (1 per pkg)	_____ Pkg(s)

DHSS Office use only:

☐ Ordered From Warehouse ☐ Entered into Inventory Database

Appendix D-4

STD TESTING PROGRAM

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

RECORD OF DRUGS

Date	Client Name	Medication Name	Dosage	Lot #	Name of Person Providing Medication

Use a separate line for each medication given to a client from STD Testing Program supply. This page may be requested for review by the STD Testing Program, Missouri Department of Health and Senior Services, for up to 3 years from the last date of entry. Providers may use their own document or produce a report from electronic records if it contains the same information and can be retrieved for a 3 year period.

2/2014

Additional Resources

Missouri Department of Health and Senior Services (DHSS) Web Site
http://www.health.mo.gov/

DHSS – HIV/STD Statistics

http://health.mo.gov/data/hivstdaids/data.php

DHSS – Hepatitis Statistics

http://health.mo.gov/living/healthcondiseases/communicable/communicabledisease/reports.php

DHSS - Bureau of HIV, STD and Hepatitis Literature Listing

http://health.mo.gov/warehouse/e-literature.html

DHSS - Bureau of HIV, STD and Hepatitis Laws, Regulations & Manuals

http://health.mo.gov/living/healthcondiseases/communicable/hivaids/lawsregs.php

DHSS – Communicable Disease Investigation Reference Manual

http://health.mo.gov/living/healthcondiseases/communicable/communicabledisease/cdmanual/index.php

St. Louis STD/HIV Prevention Training Center

http://stlouisptc.org/

Centers for Disease Control and Prevention (CDC) Web Site

http://www.cdc.gov/

CDC – STD Page

http://www.cdc.gov/std/

CDC – STD Treatment Guidelines

http://www.cdc.gov/std/treatment/

CDC – STD Fact Sheets

http://www.cdc.gov/std/healthcomm/fact_sheets.htm

CDC – HIV Page

http://www.cdc.gov/hiv/default.htm

CDC – HIV Fact Sheets

https://www.cdc.gov/hiv/library/factsheets/index.html

CDC – Hepatitis B and C Fact Sheets

http://www.cdc.gov/ncidod/diseases/hepatitis/b/index.htm

CDC – Publications and Information Products

http://www.cdc.gov/nchs/products/printed_publications.htm

CDC - Gonorrhea Fact Sheet

Basic - http://www.cdc.gov/std/gonorrhea/STDFact-gonorrhea.htm - link to printable handout
Detailed - http://www.cdc.gov/std/gonorrhea/STDFact-gonorrhea-detailed.htm

CDC- Chlamydia Fact Sheet

Basic - http://www.cdc.gov/std/Chlamydia/STDFact-chlamydia.htm - link to printable handout

Detailed - http://www.cdc.gov/std/Chlamydia/STDFact-chlamydia-detailed.htm

CDC – Syphilis Fact Sheet

Basic - http://www.cdc.gov/std/syphilis/STDFact-Syphilis.htm - link to printable handout

Detailed - http://www.cdc.gov/std/syphilis/STDFact-Syphilis-detailed.htm

*See CDC's *Sexually Transmitted Diseases Treatment Guidelines, 2015* (pp. 106-110), for a resource on discussing client concerns regarding sexual assault and STD's. A PDF copy is available at: http://www.cdc.gov/std/tg2015/tg-2015-print.pdf