Sexually Transmitted Infections
Form 2808 EXPRESS

N.C. Department of Health and Human Services
Division of Public Health *updated January 2024*

INSERT PATIENT LABEL

7a. Allergies:

7b. Medications:

DATE OF VISIT:

8a. **Reason(s) for Visit** (check all that apply)
□ STD Screen (Asymptomatic)
□ Other:

8b. **Express Triage Tool Verification** (check the box)
□ At time of visit client verifies that the following symptoms are **absent**: *Itch, irritation, pain, discharge, dysuria, ulcer/lesion, rash*

9a. **Prior STD/STI & Date Dx:**
□ Bacterial Vaginosis _____
Chlamydia _____
□ Gonorrhea _____
Genital Warts_____
□ Oral Herpes_____
□ Genital Herpes_____
□ HIV date of dx _____
state/country of dx_____
□ MPC _____
□ NGU _____
□ PID _____
□ Trichomoniasis_____
□ Yeast_____
□ Syphilis date of dx_____
state/country of dx_____
titer result:_____
county where treated:____
□ Other_____
□ None

10a. **Sexual Risk Assessment**
Sexual partners (last 60 days):
with male genitalia:_____
with female genitalia:_____
Date of last sexual encounter:

Sites of exposure (last 60 days):
□ Mouth □ Penis □ Vagina □ Anus □ None
In the last 2 weeks:
Total # sexual encounters:_____
with condom use:_____

10b. **Additional Exposure History:** "When was the last time you…"

Had sex with a person who has the same genitalia as you?	Date:_____ □ Never
Had sex with a bisexual male	Date:_____ □ Never
Had sex with a person living with HIV?	Date:_____ □ Never
Had sex with a person who uses injectable drugs?	Date:_____ □ Never
Shared needles or other works for drug use?	Date:_____ □ Never
Exchanged sex for anything (money, drugs, food, shelter)?	Date:_____ □ Never

9b. **Testing History:**

Prior HIV Test
□ no □ yes □ unknown
Last test date:_____ Result:_____

Prior Syphilis Test
□ no □ yes □ unknown
Last test date:_____ Result:_____

HBV Status
□ unknown □ acute □ chronic
Date Dx:_____

HCV Status
□ unknown □ acute □ chronic
Date Dx:_____

10c. **Do you currently use:**

Alcohol: □ no □ yes
Frequency/amount_____

Non-prescribed, injectable substances
□ no □ yes Last injection:_____

Non-injectable substances that alter your mental status:
□ no □ yes Last used:_____ List substance(s):_____

11. **For Women**

LMP: _____/_____/_____
□ regular □ irregular
frequency:_____
Are you pregnant?
□ no □ yes □ unknown
Are you breastfeeding?
□ no □ yes
Last Cervical Screening: (Pap or HPV):
date: _____
□ normal □ abnormal
Douche: □ no □ yes
frequency:_____
last use:_____

Contraception:
□ none □ emergency contraception
□ condoms □ oral contraceptive pill
□ injectable – last given:_____
□ implant – date inserted:_____
□ IUD – date inserted:_____
□ tubal ligation – date:_____
□ hysterectomy – date:_____
□ diaphragm
□ other – list:_____

12. **Laboratory**

□ Gonorrhea NAAT
□ Urine □ Rectal □ Pharyngeal □ Vaginal
□ HIV
□ Chlamydia NAAT
□ Urine □ Rectal □ Pharyngeal □ Vaginal
□ Syphilis Serology
□ Hepatitis B Serology
□ Hepatitis C Serology
□ Other: _____

13. **Instructions/Counseling**
□ Abstain from sex until test results are returned
□ Use condoms or other barrier methods for risk reduction
□ Printed risk reduction and education information
□ Reviewed services provided and tests performed
□ Referrals:

14. **Follow-up for Test Results:**
□ Clinic will call with results only if a test result is abnormal or requires re-testing
□ Results available through patient portal
□ Client will call for results
□ Unique password to obtain results by phone:_____
□ Preferred phone #s to contact client about results or follow-up:_____
□ Clinic may leave message at preferred # □ Yes □ No
□ Other:

Signature/Title of Examiner_____Date:_____

Co-Signature (if needed):_____