SEXUAL TRANSMITTED DISEASE
HISTORY AND PHYSICAL EXAM FORM
(STD-1)

Purpose

- To provide a thorough and up-to-date patient medical history and physical exam to meet program and provider requirements as well as the needs of the client for a STD office visit.

Initiation and Maintenance

- The Sexual Transmitted Disease History and Physical Exam Form (STD-1) can be initiated for visits in which the client requests STD screening, contact to a positive case, has symptoms, positive test through another program or exposure to a sexually transmitted disease.

Instructions for Completion

- Use C or D label with the patient's name, patient ID number and HID/LOC Site. If a label is not accessible, enter the patient's name, ID number, and the HID/LOC/SITE of site.
- The top 3 sections of the form are designed to be filled out by the patient and are to be reviewed with the patient by a healthcare provider at the time of the visit.
- For office visits such as Family Planning Initial/Annual or Adult Preventive Exam where a client requests STD testing, has been exposed or has symptoms and a H&P 13 or 14 has been completed, the STD-1 History section is recommended to be competed as well by the patient or the patient history would have to documented on the CH3a Progress Notes.
- The Healthcare Provider section contains check boxes designed to aid the provider in meeting program protocols/guidelines and standards for reimbursement.
    - Health Education
    - Educational Handouts given to the patient at the time of the visit.
- Patient signature, Healthcare Provider signature, and date are required to complete the patient history sections of the form.
- The Exam sections of the form are to be completed as appropriate to meet the treatment and counseling needs of the patient. Portions of this section not applicable can "X" out according to provider discretion.
- The Exam sections contains check boxes designed to aid the provider in meeting program protocols/guidelines and standards for reimbursement.
    - General Multi-System Exam,
    - Assessment and Plan
    - Testing performed,
    - Medications,
    - Recommendations to client for Follow-up testing,
    - Referrals made to the patient at the time of the visit.
- Provider signature, date and RTC Recommendations are required after completion of this section.
- Information documented in this form does not have to be repeated on the CH-3a Progress Notes.
- Recommended placement of the STD-1 is with the History and Physical section of the MR and should be filed in chronological order with the most current data on top.
- However, if the LHD chooses to place the STD-1 elsewhere in the Medical Record the arrangement should be consistent for all records in that agency.

Important - All blanks spaces and sections are to be filled in to meet PHPR program guidelines/protocols, coding and billing requirements, clinician discretion, or patient preferences. The healthcare providers will use professional judgment and program requirements to determine what medical information to gather from the client. Sections may be "X'd out" if not appropriate to the service or designated as "deferred" if omitted because of patient preference. N/A may be used to designate if the history or physical item is not applicable. The symbol "Ø" may be used when the patient reports "none at this time" during the visit. Leaving blank spaces exposes the health care provider to questions that information may have been "filled in" information or "tampered" with. See PHPR, Documentation/Medical Records Section.