INSTRUCTIONS - DHHS FORM 2808 (STD)

Item #	Description of Content	Requirements
1-6	**Demographics**	Use computer generated label or manually complete all demographic information in these sections.
7a	**Allergies**	List all allergies (e.g., drug, latex) according to agency policy
7b	**Medications**	Document antibiotics in last two weeks and any current medication.
	Date of Visit	Record the date of the client's current visit. The same form may not be used for subsequent visits.
8a	**Reason(s) for Visit**	Check all that apply using the client's words (subjective response).
	☐ STD Screen (Asymptomatic)	Example " I want to be checked." " I'm not having any problems, but…"
	☐ Symptomatic	Example " I have a problem; I'm burning." "I may have a STD."
	☐ Positive test for_____	Example " I tested positive for gonorrhea and I need to be treated."
	☐ Referred by_____	Example: DIS, Health Care Provider, or ED Example "The hospital told me to come over here and get treated." Document name and title of the referring provider**.**
	☐ Contact to person treated for _____	Example: "I think that I may have been with someone who had gonorrhea. They gave me this card." Client must provide proof of contact to a person with a confirmed or presumptive STD per agency policy. Document name of STD.
	☐ Exposed to symptomatic partner	Example: "My girlfriend has this sore and I'm afraid that I may have herpes."
	☐ Other	Check this box and document reason for visit.
8b	**Contact(s) verified by:**	Client presents as a contact to a STI. Check at least one of the options for how the contact was verified
	Partner notification card for___	Client presents with state or county issued partner notification card.
	Referral Source	Disease(s) verified by DIS, health care provider or ED
	NC EDSS Event ID	Disease(s) verified by index case NC EDSS event ID
	Verbalization of Partner/Contact	Disease(s) verified by index case; in person or by telephone call initiated by partner
	Medical Rec. Partner/Contact	Disease(s) verified by index case medical record
8c	**Symptoms / Symptom Parameters**	Question the client about each listed sign and symptom; is the sign or symptom currently present or absent? Use the client's words to describe the sign or symptom and characterize it by location, quality, severity, duration, frequency, and associated symptoms. Document the client's self-treatment and results. ***Location*** refers to the site of the sign or symptom. ***Quality*** refers to color/amount/consistency, etc. ***Severity*** refers to use of a 1-10 scale: 1 meaning a slight experience of the sign or symptom, 10 meaning the worst imaginable experience of the sign or symptom. ***Duration*** refers to the date of onset, time the complaint has been present, and/or its persistent or intermittent nature. ***Frequency*** refers to the number of times the signs or symptoms have occurred before this episode. ***Associated Symptoms*** refers to other information relevant to signs and symptoms for the chief complaint.
9a	**Prior STD/STI & Date Dx**	Check all that apply according to the client's self- reported history or from review of client's previous records. If known, document the date(s) of diagnosis.
	HIV	Document date, state, and country of diagnosis if known.
	Herpes	Choose "oral" or "genital" based on the **location** where the lesion(s) appeared.
	Syphilis	Document date, state, and country of last diagnosis if known. Document most recent titer and where the client was treated if known.
	None	Check this box if client has no prior history of STD/STI.
9b	**Vaccines & Testing**	Check status of each immunization type, # of injections, and last injection date according to NCIR, the client's self-reported history, previous visit histories, or other documents.
	Prior HIV Test	Has the client previously had an HIV test? If unknown or never tested, check the appropriate box. If client was previously tested, document the date of the most recent test.
	HBV Infection Status	Has the client been tested for Hepatitis B virus? If unknown or never tested, check the "unknown" box. If the client has been tested and diagnosed with either Acute Hepatitis B infection or Chronic Hepatitis B infection, check the appropriate box and document the date of diagnosis.
	HCV Infection Status	Has the client been tested for Hepatitis C virus? Follow the instructions for HBV Infection Status above
10a	**Sexual Risk Assessment**	Complete all parameters to include:
	Number of sexual partners within the past 60 days.	Do not assume the client's sexual orientation or partner's(s') type of genitalia. "Partner" refers to anyone with whom client has given or received oral, anal, and/or vaginal sex. If none, follow agency policy on correct documentation. No line should be left blank.
	Sites of exposure within the past 60 days	Client's anatomical sites of sexual exposure in past 60 days, i.e., mouth, penis, vagina, anus Check all that apply.
	Date of last sexual encounter	"Sexual encounter" refers to giving or receiving oral, anal, and/or vaginal sex.

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	Number of sexual encounters in the last two weeks and the # of those encounters that occurred with use of a condom	The number of times a client has had any sexual encounter during this time frame, not the number of partners. Out of that total number of sexual encounters, how many of those included condom use?
10b	**Additional exposure history**	Introduce this set of questions to client in a normalizing way, such as "We ask this next set of questions of all clients to help us identify potential risk factors for different infections" Ask "When was the last time you…" or similar open-ended question. If yes, record date of each exposure. If exposure date is within the last 6 months consider appropriate testing and risk reduction counseling. Do not assume the client's sexual orientation or partner's(s') type of genitalia.
10c	**Document current substance use**	Ask about current use of substances. Use open-ended approach as much as possible "Tell me about your alcohol use" and ask clarifying questions about frequency, amounts, types
	Alcohol use	If client drinks alcohol, ask about frequency of use (e.g., daily, on weekends, once or twice a month) and amount (e.g., one beer, two glasses of wine, three shots of liquor)
	Non-prescribed injectable substances	For example, heroin, morphine, etc. Document type and date of last injection.
	Non-injectable substances that alter your mental status	For example, marijuana, cocaine, narcotic pills. Document type, route (smoking, snorting, oral ingestion) and date of last use.
11	**For Women**	Document female-specific history: menstrual cycle, pregnancy status, breastfeeding status, cervical cancer screening history, and current contraception history
	LMP	Document date of last menstrual period, cycle regularity, and frequency. Regular = predictable and normal for the client; lasts a usual number of days, has a consistent flow pattern and quality (e.g. light on first day, heavier with clots on days 2 and three, then lighter flow and turns brown on days 4 and 5) Irregular = unpredictable or erratic; varying length of duration, varying flow pattern Frequency = time between menses (e.g., once per month, every other month, variable)
	Cervical Screening	If client seems unsure of whether they've had cervical screening, describe the main differences between a pelvic exam and cervical screening collection (either Pap or HPV specimens). Document date of last screening and the results.
12	**Comments**	Use this section to document additional information relevant to Items 1-11.
	Signatures	Signature/Title of Interviewer Signature of Interpreter (if applicable) Signature/Title of Provider if not the Interviewer
13	**Physical Examination**	Assess and check a box for all components of the exam and describe abnormal findings. Additional space to describe findings can be found in the box at the end of Item 13. If the cervix or uterus is absent due to surgical intervention, check the "abnormal" box. Male or female diagrams should reflect location of genital lesions observed during exam. Use gender-specific boxes to describe discharge, if present. If both vaginal and cervical discharge is present, clearly distinguish one from the other in your documentation.
	Vital Signs, if indicated	Vital signs may be documented if clinically indicated, e.g., client presents with signs of acute illness such as severe abdominal pain, scrotal pain, signs of allergic reaction to medication, etc.
14	**Laboratory**	Check the tests ordered and site of specimen collection. Document results of stat lab tests.
15	**Clinical Impressions/ Diagnosis**	Based on exam and lab findings and/or history, check all that apply. STD ERRNs must base clinical impressions solely on up-to-date standing orders signed by the agency medical director. The selection(s) should correspond to appropriate treatment choice(s) in Item 16 Treatment/Therapy.
	Herpes	Indicate 1st episode or recurrent; therapy should correspond.
	Syphilis	Indicate stage based on exam findings and client history
		If applicable, check the box "Contact to", "STD Screening (asymptomatic), lab tests pending" or "Other"
16	**Treatment/Therapy**	The treatment/therapy selection(s) should correspond to appropriate clinical impression selections in Item 15 Clinical Impressions/Diagnosis. If treatment is to be administered, dispensed, or applied: • review client's allergy history and check the box. • review client's pregnancy and breastfeeding status (if applicable) and check the box. • Check the box when appropriate medication instructions have been provided • Check the box when restrictions for alcohol consumption during treatment, if needed, were provided Check all treatment administered and/or prescribed. STD ERRNs (and RNs treating a client evaluated by a STD ERRN) must follow up-to-date standing orders signed by the agency medical director. A standing order must specify one treatment regimen. If an alternative treatment is indicated, e.g., due to a drug allergy, one treatment regimen must be identified in the standing order as the alternative.

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16	**Treatment/Therapy**	Complete dosage and frequency of any medication administered/dispensed (route is already specified on the form) If a client-applied treatment for warts is ordered, choose "Other" and write the product name in the space provided and record the prescription in the medical record per agency policy. Specify the name, dosage, route, and frequency of OTC treatment. The date/signature/title of person administering/dispensing treatment if not the primary provider must be documented as indicated on DHHS 2808. Every treatment choice will correspond to the selection(s) from the clinical impression/diagnosis in Item 15. "None" may be the corresponding treatment.
17	**Instructions/Counseling**	Check boxes and fill in blanks for appropriate instructions, pamphlets, referrals, and partner treatment.
18	**Follow-up for Test Results**	Document how the client will be informed about test results. Document specific criteria for obtaining test results.
	Notes:	Include important information not covered by the previous sections, especially information to enhance continuity of care if another provider sees the client on the next visit.
	Signature/Title of Examiner:	The provider completing physical exam and/or deciding the care plan for the client should sign in this space. Title should reflect his/her discipline, e.g., Enhanced Role RN, CNM, NP, PA, or MD.
	Co-signature:	This space should be used for the clinical preceptor or other required co-signature. Note: RNs providing only treatment should sign only Item 16.
	ERRN Time	Every 15-minute increment of ERRN time spent with the client equals 1 unit. 1-15 minutes = 1 unit; 16-30 minutes = 2 units; 31-45 minutes = 3 units, etc. Record the exact number of minutes spent with the client. E.g., 36 minutes = 3 units. 46 minutes = 4 units.