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. If client is transgender, check the box on the form.
7	**Allergies**	List all allergies (e.g., drug, latex) according to agency policy
	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/Check	Example " I want to be checked." "I'm here for a screening."
	☐ Asymptomatic	Example " 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 DIS or 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.
	☐ Partner with symptoms	Example: "My girlfriend has this sore and I'm afraid that I may have herpes."
	☐ Other	Check this box if client gives another reason for visit and document on the line provided.
8b	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
	Sign/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. Additional space for documentation is available in Item 13.
9a	**Prior STD/STI & Date Dx**	Check all that apply according to the client's self- reported history (verbal or by self-history form if available) and the Medical Record Problem List, if this is a returning client. If known, document the date(s) and incidence of infections. If a prior history/chart is unavailable during the current clinic visit, document the reason.
	HIV	Document date, state, and country of diagnosis if known.
	Herpes	Check the location where the lesion(s) appear.
	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 all that apply according to the client's self- reported history (verbal or by self-history form if available), previous DHHS 2808 forms, NCIR, or other documents.
	HBV Status	Has the client been tested for Hepatitis B virus? If unknown or never tested, check the box. If the client has been tested and diagnosed with either Acute Hepatitis B infection or Chronic Hepatitis B infection, check the box and document the date of diagnosis if known.
	HCV Status	Has the client been tested for Hepatitis C virus? Follow the instructions for HBV Status above
10	**Sexual Risk Assessment**	Complete all parameters to include:
	Number of male and/or female partners within the past 60 days.	Do not assume sexual orientation. "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.
	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.
	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 sex during this time frame, not the number of partners.
	Other sex partner information as listed	Ask "When was the last time you…" or "Have you ever..." Check either the yes or no box; every question should be asked and the answer should be documented.

INSTRUCTIONS - DHHS FORM 2808 (STD)

	Document alcohol use and frequency	Ask "When was the last time you drank alcohol?" or "Do you use?" If client drinks alcohol, ask when he/she had the last drink and how much.
	Document use of injectable drugs and last injection	Ask "When was the last time you shot up?" or "Do you use..?."
	Document use of other drugs	Examples of questions you might ask: "When was the last time you got high?" "What were you using?" "Do you smoke weed?" "What else are you smoking, snorting, etc.?" or "Do you use?"
11	**For Women Only**	Document menstrual history, Pap test date and results, douching practices, pregnancy and breastfeeding status, and contraceptive method.
	LMP	Regular (normal) and irregular (abnormal) refer to the quality of the period, e.g. the normal number of days, the normal flow, clots/no clots (whatever is normal for that woman).
	Frequency	Refers to time between menses, e.g. once per month, every other month, "It varies."
	Pap test	For a more accurate response, describe to the client the main differences between a pelvic exam and a Pap smear if needed.
12	**Other Pertinent History**	Document additional information in Item 13. Document antibiotics in last two weeks and any current medication. Check the box that corresponds with your agency's use and review of a client self-history form.
13	**Comments**	Use this section to document additional information relevant to Items 1-12. *If the client is returning for treatment only, follow the printed instructions.
		Signature of Interpreter (if applicable) and Date Signature/Title of Interviewer and Date Signature/Title of Provider if not the Interviewer and Date
14	**Physical Examination*** (see statement below #13 "Comments" on Form 2808)	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 14. 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.
15	**Laboratory**	Check the test and site of all laboratory procedures ordered. Document results of stat lab tests.
16	**Clinical Impressions/ Diagnosis**	This section should correspond to Item 17 Treatment/Therapy. 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.
	Herpes	Circle 1st episode or recurrent; therapy should correspond.
		Every exam and/or laboratory test will result in a clinical impression.
		Check the box "Normal STD Screening, lab tests pending" or "Other" if applicable.
17	**Treatment/Therapy**	This section should correspond to Item 16 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 all treatment administered and/or prescribed. There should be a documented clinical impression that supports each treatment. 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. A Registered Nurse may make no choices about which treatment regimen to prescribe per standing order.
		Fill in the number of days that Doxycycline has been ordered.
		Circle the name of the medication administered/dispensed when more than one type is listed on DHHS 2808, e.g. Acyclovir/Valacyclovir/Famciclovir. Medication must be supported by a standing order when selected by a STD ERRN.
		If a client-applied treatment for warts is ordered, 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.
		Provide medication instructions according to policy and check the corresponding box. If alcohol consumption is restricted due to treatment, check the box and document the treatment plan.
		Every clinical impression/diagnosis will result in a checked box in Item 17; "None" may be the corresponding treatment.
18	**Instructions/Counseling**	Check boxes and fill in blanks for appropriate instructions, pamphlets, referrals, and partner treatment.
19	**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.
	Primary Provider Signature:	The provider examining and deciding the care plan for the client should sign in this space. Note: Primary provider should check the box reflecting 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 17.
	Time Enhanced Role RN spent with client:	15 minutes equals 1 unit. Record the exact number of minutes spent with the client. Ex: 46 minutes = 3 units. 44 minutes = 2 units.