

# Disseminated Gonococcal Infection Case Reporting

CDC has received increasing reports of disseminated gonococcal infection (DGI), an uncommon, but severe, complication of untreated gonorrhea. The CDC DGI Case Report Form and REDCap Survey can be used by state and local health departments to collect the detailed epidemiologic, clinical, and behavioral data elements we need to better understand and characterize DGI cases nationally. Follow the instructions below to voluntarily share existing and available epidemiological and clinical DGI case information with CDC. The submission of all data elements is not required. Keep a record of the REDCap ID with your local case ID so you can modify the form if any additions or changes are needed. **Please note that this form/tool does not replace the National Notifiable Diseases Surveillance System (NNDSS) case notification process.** Effective January 2023, the [national case definition for gonorrhea](#) was updated to distinguish between DGI and non-DGI cases. Gonorrhea case notifications provided to CDC's NNDSS via HL7 standards in the STD Message Mapping Guide should indicate if the case was identified as DGI.

## DGI Case Report Form (Version 2 September 2023) Instructions

**Please contact your state health department to discuss the DGI case report submission process before submitting to CDC; state health departments may prefer to receive DGI reports from local jurisdictions and submit to CDC directly.**

*Note:* This form is for your records. To share information on a DGI case, the information in this form should be entered into the REDCap Survey.

### Information Needed to Compete Form

- Medical record reviews
- Partner service investigations
- Provider interviews
- Information from various staff (e.g., surveillance, DIS)

### DGI Case Classification Definitions Used in Form ([CSTE gonorrhea position statement](#))

- **Verified:** Isolation or detection of *Neisseria gonorrhoeae* from a disseminated site of infection (e.g., skin, synovial fluid, blood, or cerebrospinal fluid [CSF]) by culture or nucleic acid amplification test (NAAT).
- **Likely:** In the absence of a more likely diagnosis, clinical suspicion of DGI AND isolation or detection of *N. gonorrhoeae* from a mucosal site of infection by culture or NAAT.

### REDCap Survey Instructions

The information in the DGI Case Report Form should be entered into a REDCap survey behind the SAMS firewall. REDCap will assign a unique ID to each case entered. Please keep a record of the REDCap ID with the corresponding case report form. Each page of the DGI Case Report Form has a box to record the REDCap ID. The REDCap form includes skip patterns so some questions on the form may not be applicable to every case.

To upload information in REDCap:

#### Request Direct Access to the REDCap Survey

1. If someone at your agency already has access to REDCap behind the SAMS firewall (i.e., congenital syphilis form submission), they can request access to the DGI project by emailing their REDCap ID (a 5-6 digit number) to [CDC](#).
2. If someone at your agency has SAMS access but not access to REDCap, they can email [CDC](#) to request access.
3. If no one at your agency has SAMS access, please contact [CDC](#) to discuss a secure way to transfer the completed DGI Case Report Form and to receive a REDCap case ID for your record.

If you have any questions, please feel free to reach out to us for assistance.

Sincerely,



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# Disseminated Gonococcal Infection Case Report Form (Version 2 September 2023)

REDCap Case ID (Generated by REDCap): \_\_\_\_\_

## REPORTER INFORMATION

Date Form Completed (MM/DD/YYYY): \_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_ Phone No: \_\_\_\_\_

Agency: \_\_\_\_\_ Email: \_\_\_\_\_

## CASE INFORMATION

**1a. Was case sent to CDC's NNDSS as a gonorrhea case?**

- Yes (Answer 1b)  
 No  
 Unknown

**1b. If yes, was the case sent via:**  NETSS  MMG

If case sent via NETSS:

State: \_\_\_\_\_

MMWR Year: \_\_\_\_\_

Case Report ID: \_\_\_\_\_

Site Code: \_\_\_\_\_

If case sent via MMG:

National Reporting Jurisdiction (77968-6): \_\_\_\_\_

Local record ID (N/A: OBR-3): \_\_\_\_\_

**2. How was this case identified? (Check all that apply):**

- Provider report  
 Laboratory report  
 Other, specify \_\_\_\_\_

**3. Case classification\* for disseminated infection:**

- Verified  
 Likely

**\*Case Classification**

Verified: Isolation or detection of *Neisseria gonorrhoeae* from a disseminated site of infection (e.g., skin, synovial fluid, blood, or cerebrospinal fluid [CSF]) by culture or nucleic acid amplification test (NAAT)

Likely: In absence of a more likely diagnosis, clinical suspicion of DGI AND isolation or detection of *N. gonorrhoeae* from a mucosal site by culture or NAAT

**4. Date first reported to health department:**

(MM/DD/YYYY): \_\_\_\_\_

## CASE INFORMATION: DEMOGRAPHIC INFORMATION

**1. State of Residence**

- \_\_\_\_\_  
 Not a US resident  
 Unknown

**2. County of Residence:**

- \_\_\_\_\_  
 Not applicable  
 Unknown

**3. Age (In years):**

- \_\_\_\_\_  
 Unknown

**4. Sex Assigned at Birth:**

- Male  
 Female  
 Unknown

**5. Current Gender:**

- Male gender  Gender diverse or non-binary  
 Female gender  Other gender identity  
 Transgender male  Unknown  
 Transgender female

**6. Race (Check all that apply):**

- White  American Indian or Alaska Native  Asian  Unknown  
 Black  Native Hawaiian or Other Pacific Islander  Other race

**7. Hispanic Ethnicity:**

- Hispanic or Latino  Unknown  
 Not Hispanic or Latino

## CASE INFORMATION: PREGNANCY STATUS

**1. At time of DGI diagnosis, patient was:**

- Pregnant (Answer 2, 3)  Neither  
 Postpartum\* (Answer 2, 3)  Unknown

**2a. If pregnant or postpartum, what is the estimated due date?**

(MM/DD/YYYY): \_\_\_\_\_

\*Postpartum = up to one year

**2b. If pregnant or postpartum, what is the date of the pregnancy outcome?**

(MM/DD/YYYY): \_\_\_\_\_

**3a. If pregnant or postpartum, what was the outcome of the fetus?**

- Live birth, no apparent illness  Termination  
 Live birth, clinical infection with *N. gonorrhoeae* (Answer 3b)  Still pregnant  
 Live birth with neonatal death before 30 days  Unknown  
 Still birth (Gestational age ≥ 20 weeks)  
 Spontaneous abortion/miscarriage (Gestational age < 20 weeks)

**3b. If live birth with clinical infection with *N. gonorrhoeae*, what were the signs/symptoms?**

Signs/Symptoms: \_\_\_\_\_

## PAST MEDICAL HISTORY (Check all that apply; include ANY known past medical history ever during lifetime)

**1. Condition/Diagnosis**

**Yes / No / Unknown**

- |  |                              |                             |                                  |
|--|------------------------------|-----------------------------|----------------------------------|
| Complement deficiency  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Previous disseminated gonococcal infection (DGI)                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Previous meningococcal infection                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| HIV infection  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Atypical hemolytic uremic syndrome (aHUS)                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Generalized myasthenia gravis (GMG)                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Paroxysmal nocturnal hemoglobinuria (PNH)                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Immunosuppressive therapy (e.g. steroids, chemotherapy, radiation) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Systemic lupus erythematosus (SLE)                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Diabetes mellitus  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Hepatitis C infection  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Hepatitis B infection  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Malignancy   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Other  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

If yes, specify \_\_\_\_\_

If yes, specify \_\_\_\_\_

2a. Did the patient receive any antibiotics in the 1 month prior to the current DGI diagnosis?  Yes (Answer 2b)  No  Unknown

2b. If yes:

Antibiotic	Dose (mg)	Route (IV, IM, PO)	Frequency (Every ___ hours)	Duration (Days)	Date Started (MM/DD/YYYY)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

3a. Prior to this gonococcal infection, did the patient receive or have history of receiving the medication Eculizumab (or other biologic agents that inhibit the complement cascade)?  Yes (Answer 3b)  No  Unknown

3b. If yes:  
If not receiving Eculizumab, what complement-inhibiting biologic agent did the patient receive? \_\_\_\_\_

What was the date of the last dose in which Eculizumab (or other complement-inhibiting biologic agent) was administered (MM/DD/YYYY)? \_\_\_\_\_

Did the patient receive antibiotic prophylaxis as a result of the receipt of this medication?  Yes  No  Unknown

If yes, please specify which antibiotic (name and dose) they received? \_\_\_\_\_

DGI CLINICAL COURSE: UROGENITAL, PHARYNGEAL, AND RECTAL SYMPTOMS

1a. Was the patient experiencing symptoms of urogenital, pharyngeal, or rectal gonorrhea at the time of or within a month prior to DGI presentation?

Yes (Answer 1b)  No  Unknown

1b. If yes, when did the patient first seek medical care for the symptoms of urogenital, pharyngeal, or rectal gonococcal infection (MM/DD/YYYY)?	Symptom	Yes / No / Unknown	Date of Onset (MM/DD/YYYY)
_____	Penile/Vaginal discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
_____	Dysuria	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
_____	Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
_____	Rectal bleeding, discharge, and/or pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
_____	Abdominal or pelvic pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
_____	Testicular pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
_____	Other, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____

DGI CLINICAL COURSE: DGI CLINICAL PRESENTATION, MANAGEMENT, AND OUTCOME

1. When did the patient first develop DGI symptoms (e.g., fever, chills, malaise, rash, joint pain or swelling) (MM/DD/YYYY)? \_\_\_\_\_

2. When did the patient first seek medical care for the DGI symptoms (MM/DD/YYYY)? \_\_\_\_\_

3. In what types of medical facilities was the patient evaluated or treated for DGI symptoms, even if a diagnosis was not made (Check all that apply)?

- Emergency Department
- Urgent care clinic
- Primary care clinic (e.g., Family Practice, Internal Medicine, Pediatrics)
- STD specialty clinic
- Other specialty clinic (e.g., Sports Medicine/Orthopedics, Rheumatology, Infectious Diseases, OB/GYN)
- Inpatient hospital service(s)
- Other, specify: \_\_\_\_\_
- Unknown

4a. Clinical Manifestations of DGI (Check all that apply):

- Fever
- Bacteremia
- Endocarditis
- Hepatitis
- Meningitis
- Myocarditis
- Skin lesions; if yes, please describe: \_\_\_\_\_
- Polyarthralgia
- Septic arthritis
- Tenosynovitis
- Osteomyelitis
- Other, specify: \_\_\_\_\_
- Unknown

4b. If the patient was diagnosed with septic arthritis, what anatomic sites were involved? (Check all that apply)

- Knee  Ankle
- Wrist  Spine
- Other, please specify: \_\_\_\_\_
- Unknown

4c. If the patient was diagnosed with osteomyelitis, what anatomic sites were involved? (Check all that apply)

- Knee  Ankle
- Wrist  Spine
- Other, please specify: \_\_\_\_\_
- Unknown

5a. Was the patient admitted to a hospital for DGI management (i.e., hospitalized as inpatient)?

- Yes (Answer 5b)
- No
- Unknown

5b. If yes:

Total Number of Days Hospitalized

\_\_\_\_\_

6a. Did the patient have any procedures (inpatient or outpatient) related to DGI?

Yes (Answer 6b)  No  Unknown

6b. If yes, check all that apply:

- Joint aspiration
- Lumbar puncture
- Skin biopsy
- Transesophageal echocardiogram
- Joint washout, debridement, or operative incision and drainage
- Heart valve replacement surgery
- Other

If other, please describe: \_\_\_\_\_

7a. What was the clinical outcome of the DGI case?  Survived  Died  Unknown

7b. If the patient died, what was the cause(s) of death: \_\_\_\_\_

7c. Date of Death (MM/DD/YYYY): \_\_\_\_\_

**DGI TREATMENT (After DGI diagnosis was made)**

Medication	Dose (mg)	Route (IV, IM, PO)	Frequency (Every ___ hours)	Duration (Days)	Date Started (MM/DD/YYYY)
1a. Ceftriaxone	_____	_____	_____	_____	_____
1b. Cefixime	_____	_____	_____	_____	_____

1c. During the clinical course, did the patient receive additional antimicrobial treatment not already described above?  No  Yes  Unknown  
 If yes, which antimicrobials? (Check all that apply)      Duration of treatment (days)      Date started (MM/DD/YYYY)

- Vancomycin IV \_\_\_\_\_
- Piperacillin/tazobactam (Zosyn) \_\_\_\_\_
- Cefepime \_\_\_\_\_
- Meropenem \_\_\_\_\_
- Doxycycline (IV or PO) \_\_\_\_\_
- Ciprofloxacin (IV or PO) \_\_\_\_\_
- Amoxicillin/clavulanic acid (Augmentin) \_\_\_\_\_
- Other, please specify: \_\_\_\_\_
- Unknown \_\_\_\_\_

2a. Did the patient complete the prescribed treatment for DGI?  No  Yes  Unknown

2b. If no: why was the prescribed treatment not completed?  
 Patient left against medical advice       Other reason, specify \_\_\_\_\_  
 Patient was discharged before diagnosis was received       Unknown

**LABORATORY RESULTS (Use a separate line for each specimen tested)**

Was *N. gonorrhoeae* testing performed at disseminated sites of infection during the current DGI presentation?  Yes (Complete table)  No  Unknown

Date of Specimen Collection (MM/DD/YYYY)	Specimen Type (Select one)	Diagnostic Test Type (Select one)	Result (Select one)
_____	<input type="checkbox"/> Blood <input type="checkbox"/> Skin lesion <input type="checkbox"/> Synovial fluid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> CSF* <input type="checkbox"/> Unknown	<input type="checkbox"/> NAAT* <input type="checkbox"/> Culture <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminant <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Blood <input type="checkbox"/> Skin lesion <input type="checkbox"/> Synovial fluid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> CSF* <input type="checkbox"/> Unknown	<input type="checkbox"/> NAAT* <input type="checkbox"/> Culture <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminant <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Blood <input type="checkbox"/> Skin lesion <input type="checkbox"/> Synovial fluid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> CSF* <input type="checkbox"/> Unknown	<input type="checkbox"/> NAAT* <input type="checkbox"/> Culture <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminant <input type="checkbox"/> Unknown

Please provide details for any other *N. gonorrhoeae* testing performed at disseminated sites of infection.

\*CSF=cerebrospinal fluid; NAAT=nucleic acid amplification test

Was *N. gonorrhoeae* testing performed at urogenital, pharyngeal, and rectal sites in the 3 months prior to or associated with the current DGI presentation/diagnosis?

Yes (Complete table)  No  Unknown

Date of Specimen Collection (MM/DD/YYYY)	Specimen Type (Select one)	Diagnostic Test Type (Select one)	Result (Select one)
_____	<input type="checkbox"/> Urine <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Endocervical <input type="checkbox"/> Rectal <input type="checkbox"/> Vaginal <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Urethral <input type="checkbox"/> Unknown	<input type="checkbox"/> NAAT* <input type="checkbox"/> Culture <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminant <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Urine <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Endocervical <input type="checkbox"/> Rectal <input type="checkbox"/> Vaginal <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Urethral <input type="checkbox"/> Unknown	<input type="checkbox"/> NAAT* <input type="checkbox"/> Culture <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminant <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Urine <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Endocervical <input type="checkbox"/> Rectal <input type="checkbox"/> Vaginal <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Urethral <input type="checkbox"/> Unknown	<input type="checkbox"/> NAAT* <input type="checkbox"/> Culture <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminant <input type="checkbox"/> Unknown

Please include any additional *N. gonorrhoeae* testing performed at urogenital, pharyngeal and rectal sites in the 3 months prior to and including the current DGI presentation.

\* NAAT=nucleic acid amplification test

Were any available *N. gonorrhoeae* isolates sent to CDC for further testing?  Yes  No  Unknown

If yes: what was the date of shipment to CDC? (MM/DD/YYYY) \_\_\_\_\_

ADDITIONAL COMMENTS (e.g., additional patient history, clinical course, etc.):

\_\_\_\_\_

FOR CDC USE ONLY: CDC LRRB Assigned ID: \_\_\_\_\_

BEHAVIORAL AND PARTNER INFORMATION (Collected from medical chart review and/or patient interview)

1. Gender of sex partners in the past 12 months (Check all that apply):

Male  Female  Transgender male  Transgender female  Gender diverse or non-binary  Other gender identity  Unknown

2. Exchanged money, food/lodging, or drugs for sex in the past 12 months:  Yes  No  Unknown

3. Homelessness (e.g., living on the street, in a shelter/a single-room occupancy hotel, in a car) at any time during the past 12 months:

Yes  No  Unknown

4. Incarcerated in the past 12 months:  Yes  No  Unknown

5. Reports using the drug in the past 12 months (or positive drug test)

Drug		If used in past 12 months, was it injected?
5a. Methamphetamine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5b. Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5c. Other opioid, excluding prescription painkillers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5d. Prescription painkillers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5e. Cocaine/Crack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5f. Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

6a. Was the patient interviewed by a Disease Intervention Specialist (DIS) or other public health staff?  Yes (Answer 6b)  No  Unknown

If yes:

6b. Did the patient report any sex or needle sharing partners or associates:  Yes  No  Unknown

If partner information available, complete the table below.

Partner	Partner Gender (Select one)	Partner Type (Select one)	Locating Information Provided (Select one)	Interview Performed (Select one)	Gonorrhea Case (Select one)	DGI Case (Select one)	Isolate Sent to CDC for Additional Testing (Select one)
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender diverse or non-binary <input type="checkbox"/> Other gender identity <input type="checkbox"/> Unknown	<input type="checkbox"/> Sex <input type="checkbox"/> Needle sharing <input type="checkbox"/> Sex <i>AND</i> needle sharing <input type="checkbox"/> Associate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender diverse or non-binary <input type="checkbox"/> Other gender identity <input type="checkbox"/> Unknown	<input type="checkbox"/> Sex <input type="checkbox"/> Needle sharing <input type="checkbox"/> Sex <i>AND</i> needle sharing <input type="checkbox"/> Associate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender diverse or non-binary <input type="checkbox"/> Other gender identity <input type="checkbox"/> Unknown	<input type="checkbox"/> Sex <input type="checkbox"/> Needle sharing <input type="checkbox"/> Sex <i>AND</i> needle sharing <input type="checkbox"/> Associate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender diverse or non-binary <input type="checkbox"/> Other gender identity <input type="checkbox"/> Unknown	<input type="checkbox"/> Sex <input type="checkbox"/> Needle sharing <input type="checkbox"/> Sex <i>AND</i> needle sharing <input type="checkbox"/> Associate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender diverse or non-binary <input type="checkbox"/> Other gender identity <input type="checkbox"/> Unknown	<input type="checkbox"/> Sex <input type="checkbox"/> Needle sharing <input type="checkbox"/> Sex <i>AND</i> needle sharing <input type="checkbox"/> Associate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender diverse or non-binary <input type="checkbox"/> Other gender identity <input type="checkbox"/> Unknown	<input type="checkbox"/> Sex <input type="checkbox"/> Needle sharing <input type="checkbox"/> Sex <i>AND</i> needle sharing <input type="checkbox"/> Associate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Include information on any additional partners.

**FOR CDC USE ONLY**  
 If partner isolate was sent to CDC for additional testing:  
 CDC LRRB Assigned ID: \_\_\_\_\_