PART 9: APPENDICES

- Sample Patient Contact Form
- Maryland Confidential Morbidity Report (DHMH 1140)
- Sample Partner Notification Letter from Provider
- Sample Partner Notification Referral Cards
- Sample Intimate Partner Violence (IPV) Assessment
- Request for Confidential Communications Form
- Maryland Local Health Departments
- Baltimore City Health Department STI Clinics
- Ocular Syphilis and Neurosyphilis Screening Guide
- References
Sample Patient Contact Form

Patient______________________________________ Birth Date________________________________

Address____________________________________________________________________________

*Please identify the best ways for us to reach you to coordinate your medical care. Please check all that apply. Today’s date is_______________________

By mail

☐ At the address above
☐ At this address________________________________________________________

By phone (List number) May we leave a message? (Circle Yes/No)

☐ Home ___________________________ Yes / No
☐ Cell ___________________________ Yes / No
☐ Work ___________________________ Yes / No
☐ Other ___________________________ Yes / No

May we identify ourselves when we call?

☐ Yes
☐ No
☐ If No, who should we say has called so that you know to call us back?_______________

Does it matter whether a male or female office assistant makes the call?

☐ Yes, female assistants only
☐ Yes, male assistants only
☐ No, it does not matter

What are the best days and times to reach you? ______________________________________

If we are unable to reach you according to the plan above, is there someone else we can call who will help us reach you?

☐ Yes (Please provide name, relationship, and phone number on the line below)

__________________________________________________________________________

☐ No

If there anything else that you would like for us to know or do in order to establish optimal contact, please describe below.

__________________________________________________________________________

__________________________________________________________________________

Adapted from the Iowa Department of Public Health
## Maryland Confidential Morbidity Report (DHMH 1140)

**For use by physicians and other health care providers, but not laboratories. Laboratories should use forms DHMH 1281 & DHMH 4492.**

SEND TO YOUR LOCAL HEALTH DEPARTMENT

### Demographic Data

<table>
<thead>
<tr>
<th>Patient’s Name (Last)</th>
<th>(First)</th>
<th>(M.I.)</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Sex at Birth</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County of Residence</th>
<th>Home Telephone</th>
<th>Cellphone</th>
<th>Work Telephone</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Occupation or Contact with Vulnerable Persons

- [ ] Food Service Worker
- [ ] Not Employed
- [ ] Health Care Worker
- [ ] Daycare
- [ ] Parent of Daycare Child
- [ ] Other (Specify): ________________

### Work Place, School, Child Care Facility, Etc.

(include Name, Address, Zipcode)

### Morbidity Data

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>Date of Onset</th>
<th>Patient Notified of this Condition</th>
<th>Pertinent Clinical/Information/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Hospitalized</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Died of This Illness</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Pregnant</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, Due date (mm/dd/yyyy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weeks Pregnant</th>
<th>Unknown</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interstate</td>
<td>Interstate</td>
<td>International</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Lab Results (Specimen – Test – Result – Date – Name of Lab) Please attach copies of lab reports whenever possible.

### Laboratory Results

<table>
<thead>
<tr>
<th>Hepatitis</th>
<th>Date</th>
<th>Result</th>
<th>Risk Exposure (Select all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAV Antibody Total</td>
<td>POS</td>
<td>NEG</td>
<td>DATE</td>
</tr>
<tr>
<td>HAV Antibody IgM</td>
<td>POS</td>
<td>NEG</td>
<td>DATE</td>
</tr>
<tr>
<td>HBV surface Antigen</td>
<td>POS</td>
<td>NEG</td>
<td>DATE</td>
</tr>
<tr>
<td>HBV e Antigen</td>
<td>POS</td>
<td>NEG</td>
<td>DATE</td>
</tr>
<tr>
<td>HBV core Antibody Total</td>
<td>POS</td>
<td>NEG</td>
<td>DATE</td>
</tr>
<tr>
<td>HBV core Antibody IgM</td>
<td>POS</td>
<td>NEG</td>
<td>DATE</td>
</tr>
</tbody>
</table>

### HIV and AIDS

<table>
<thead>
<tr>
<th>HIV Lab Tests</th>
<th>Date</th>
<th>Result</th>
<th>Complete for HIV/AIDS or STI</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Diagnoistic (Specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD4+ T-cells</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Viral Load</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Genotype (Resistance)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Testing Lab</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sexually Transmitted Infection

<table>
<thead>
<tr>
<th>Syphilis Stage</th>
<th>Syphilis Symptoms</th>
<th>Gonorrhea Site(s)</th>
<th>Chlamydia Site(s)</th>
<th>Other STI (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Lesion</td>
<td>Cervical</td>
<td>Cervical</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>Secondary</td>
<td>Palmar/Plantar Rash</td>
<td>Urethral</td>
<td>Urethral</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>Early Latent (&lt;1 yr)</td>
<td>Condylomata Lata</td>
<td>Rectal</td>
<td>Rectal</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>Congenital</td>
<td>Neurologic</td>
<td>Pharyngeal</td>
<td>Pharyngeal</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>Other Stage (specify)</td>
<td>Other (specify)</td>
<td>Ophthalmia Neanoturnum</td>
<td>P/D</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

### STI Treatment Given

([Specify date – drug – dosage below]) No Treatment Given

### Reporting Source (Required)

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Telephone No.</th>
<th>Check here if completed by the Local Health Department</th>
<th>Date of Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes:

Your local health department may contact you following this initial report to request additional disease-specific information.

To print blank report forms or get more information about reporting, go to http://phpa.dhm.maryland.gov/SitePages/what-to-report.aspx

DHMH 1140
Revised 07/2015
Sample Partner Notification Letter from Provider

Date: ____________________________

Dear ____________________________

Someone you had sex with has been diagnosed with a sexually transmitted infection (STI). Because you may have been exposed to this infection, you could also be infected. Most STIs can be easily treated with an antibiotic (medication) that you can get from a medical provider. Your provider might test you for other sexually transmitted infections, or may need to examine you.

Just so you know, you can be infected with an STI and have NO symptoms. Actually, most infected people do not have symptoms, but if not treated, STIs can cause serious health problems. You also may spread the infection to other people you have sex with, so you should go to your medical provider as soon as possible to get treatment. It is very important that you take all of the medication you are given, and you should not have sex with anyone until seven days after you finish taking your medicine to make sure that the medicine works.

If you get tested for an STI and the test is positive, it is very important that you tell all sexual partners you have had in the past two months to get antibiotic treatment. If your current or past partners do not get treatment, they can re-infect you or they can infect other people with whom they have sex. STIs can be spread through oral, vaginal, or anal sex.

Please ask your medical provider for more information or to answer any questions that you have about any of the information in this letter. If you do not have a medical provider, please read the list on the back of this letter for some clinics that will treat you confidentially and free-of-charge. You can also visit gettested.cdc.gov to find clinics near you that perform STI and HIV testing for free or at low-cost.

Sincerely,
Sample Partner Notification Referral Cards

Your partner has just told you that they have been diagnosed with a sexually transmitted infection.

- STIs are spread through vaginal, oral, or anal sex.
- Most STIs are easily treated with an antibiotic (medication).
- If left untreated, STIs can cause serious health problems.
- You may be infected and have no symptoms.

**Get Tested and Treated**
Take this sheet to your healthcare provider or to a local STI clinic

For more information or to locate a clinic, call the 24 hour free STD hotline at 1-800-CDC-INFO or visit https://gettested.cdc.gov

Your partner has just told you that they have been diagnosed with a sexually transmitted infection.

- STIs are spread through vaginal, oral, or anal sex.
- Most STIs are easily treated with an antibiotic (medication).
- If left untreated, STIs can cause serious health problems.
- You may be infected and have no symptoms.

**Get Tested and Treated**
Take this sheet to your healthcare provider or to a local STI clinic

For more information or to locate a clinic, call the 24 hour free STD hotline at 1-800-CDC-INFO or visit https://gettested.cdc.gov
Sample Partner Notification Referral Cards

Your partner has just told you that they have been diagnosed with a sexually transmitted infection.

- STIs are spread through vaginal, oral, or anal sex.
- Most STIs are easily treated with an antibiotic (medication).
- If left untreated, STIs can cause serious health problems.
- You may be infected and have no symptoms.

**Get Tested and Treated**
Take this sheet to your healthcare provider or to a local STI clinic

For more information or to locate a clinic, call the 24 hour free STD hotline at 1-800-CDC-INFO
or visit [https://gettested.cdc.gov](https://gettested.cdc.gov)

Low cost services available through
Baltimore city Health Department:
410-396-0185 (West) or 410-396-9401 (East)

---

Your partner has just told you that they have been diagnosed with a sexually transmitted infection.

- STIs are spread through vaginal, oral, or anal sex.
- Most STIs are easily treated with an antibiotic (medication).
- If left untreated, STIs can cause serious health problems.
- You may be infected and have no symptoms.

**Get Tested and Treated**
Take this sheet to your healthcare provider or to a local STI clinic

For more information or to locate a clinic, call the 24 hour free STD hotline at 1-800-CDC-INFO
or visit [https://gettested.cdc.gov](https://gettested.cdc.gov)

Low cost services available through
Baltimore city Health Department:
410-396-0185 (West) or 410-396-9401 (East)
Sample Intimate Partner Violence Assessment

- Assess privately, without family/friends; use interpreter (not family/friend) if needed;
- Assess females, ages 15-50, at every new, interval comprehensive, or urgent care health visit – as part of routine health history. Assess obstetric patients every trimester and postpartum. Ask directly or have patient self-administer the questions by computer or paper.
- Assess anyone when signs and symptoms raise concerns about violence (injuries, drug/alcohol use, STIs, psych disorders). Or at provider discretion.

Introductory statements:
- "Because violence is so common and help is available, I now ask every patient if they are being hurt by a current or former partner."
- "I won’t tell anyone else about what is said unless you give me permission."
[Exceptions for Maryland: abuse of vulnerable adults, children < 18 years of age by a guardian, or certain injuries, e.g. inflicted by gun or moving vessel]?

Sample questions:
1. "Has your current or former partner threatened you or made you feel afraid?"
   (stalked you, insulted you, threatened you with a weapon, threatened to hurt you or your children if you did or didn’t do something, controlled whom you talk to/where you go/how you spend money)
2. "Has your partner hit, strangled or physically hurt you?"
   ("hurt" includes being hit, slapped, kicked, "choked" [or strangled], bitten, shoved)
3. "Has your partner made you have sex when you didn’t want to?"

No

Yes (to any of above 3 questions)

"It is not your fault. You are not alone. Help is available. I’m concerned about your safety (and safety of your children). Abuse tends to increase in frequency/intensity and it can impact your health"

Sample questions to quickly assess: Is it safe to go home? 4
a. Has the physical violence increased over the past 6 months?
b. Has your partner used a weapon or threatened you with a weapon?
c. Do you believe your partner is capable of killing you?
d. Have you been beaten while pregnant?
e. Is your partner violently and constantly jealous of you?

Note: Patient may be a danger to herself. Assess for depression/suicidality

"Yes" to ≥3 out of 5 questions* or concern for safety - “From what you’ve told me, you are at high risk for severe injury or even being killed by your abuser. Let’s make a call to help you decide some safe options for you and your family.” (Remember that the goal may not be leaving at once but discussing safety with a DV expert. Document if help is declined but respect patient autonomy for making decision.)

Offer to call National Hotline 800-799-SAFE or the local DV Program (see back) for safety assessment/planning, counseling, legal advice, shelter. Make other referrals [mental health] as needed; Schedule a follow up visit

Emphasize the need to keep information private and away from abuser.


- Educate and counsel as needed; discuss healthy relationships and give out safety cards* women’s health resource list (with local DV contact information)
- By providing brochures, cards, resources and information to all women or for their ‘friends or family who may be dealing with violence’ women can receive important information without disclosure.

---

1 Intimate Partner Violence: A guide for Health Care Providers*, available at www.dbhm.maryland.gov/ipv/ has more information about IPV assessment, documentation, reporting requirements, special populations, resources and how to order safety cards
3 Other IPV assessment tools such as "HITS" may be found at www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf
4 adapted from Academic Emergency Medicine 2009; 16:1208–1216
<table>
<thead>
<tr>
<th>County</th>
<th>Program</th>
<th>Daytime Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegany</td>
<td>Family Crisis Resource Center</td>
<td>301-759-5946</td>
</tr>
<tr>
<td>Anne Arundel</td>
<td>YWCA Domestic Violence Services</td>
<td>410-626-7800</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>House of Ruth MD</td>
<td>410-889-0840</td>
</tr>
<tr>
<td></td>
<td>TurnAround, Inc.</td>
<td>410-837-7000</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Family and Children’s Services of Central MD</td>
<td>410-281-1334</td>
</tr>
<tr>
<td></td>
<td>Family Crisis Center of Baltimore County, Inc.</td>
<td>410-285-4357</td>
</tr>
<tr>
<td></td>
<td>TurnAround, Inc.</td>
<td>410-377-8111</td>
</tr>
<tr>
<td>Calvert</td>
<td>Crisis Intervention Center</td>
<td>410-535-5400 x384</td>
</tr>
<tr>
<td>Carroll</td>
<td>Family and Children’s Services of Central MD</td>
<td>410-876-1233</td>
</tr>
<tr>
<td>Caroline</td>
<td>Mid-Shore Council on Family Violence</td>
<td>410-479-1149</td>
</tr>
<tr>
<td>Cecil</td>
<td>Cecil Co. Domestic Violence/Rape Crisis Center</td>
<td>410-996-0333</td>
</tr>
<tr>
<td>Charles</td>
<td>Center for Abused Persons</td>
<td>301-645-8994</td>
</tr>
<tr>
<td>Dorchester</td>
<td>Mid-Shore Council on Family Violence</td>
<td>410-479-1149</td>
</tr>
<tr>
<td>Frederick</td>
<td>Heartly House</td>
<td>301-418-6610</td>
</tr>
<tr>
<td>Garrett</td>
<td>The Dove Center</td>
<td>301-334-6255</td>
</tr>
<tr>
<td>Harford</td>
<td>Sexual Assault/Spouse Abuse Resource Center</td>
<td>410-836-8431</td>
</tr>
<tr>
<td>Howard</td>
<td>Domestic Violence Center</td>
<td>410-997-0304</td>
</tr>
<tr>
<td>Kent</td>
<td>Mid-Shore Council on Family Violence</td>
<td>410-479-1149</td>
</tr>
<tr>
<td>Montgomery</td>
<td>Abused Persons Program</td>
<td>240-777-4210</td>
</tr>
<tr>
<td>Prince George’s</td>
<td>Family Crisis Center, Inc.</td>
<td>301-779-2100</td>
</tr>
<tr>
<td></td>
<td>House of Ruth MD (legal, counseling services)</td>
<td>240-450-3270</td>
</tr>
<tr>
<td>Queen Anne’s</td>
<td>Mid-Shore Council on Family Violence</td>
<td>410-479-1149</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>Walden/Sierra, Inc.</td>
<td>301-863-6677</td>
</tr>
<tr>
<td>Somerset</td>
<td>Life Crisis Center</td>
<td>410-749-0771</td>
</tr>
<tr>
<td>Talbot</td>
<td>Mid-Shore Council on Family Violence</td>
<td>410-479-1149</td>
</tr>
<tr>
<td>Washington</td>
<td>CASA (Citizens Assisting and Sheltering the Abused)</td>
<td>301-739-4990</td>
</tr>
<tr>
<td>Wicomico</td>
<td>Life Crisis Center</td>
<td>410-749-0771</td>
</tr>
<tr>
<td>Worcester</td>
<td>Life Crisis Center</td>
<td>410-749-0771</td>
</tr>
</tbody>
</table>

Resources

Hotlines: 24/7

National Domestic Violence Hotline
1-800-799-SAFE (7233)
1-800-787-3224 TTY
(interpreters for 170 languages and links to local DV hotline)

National Teen Dating Abuse
1-866-331-9474
On-line chat
www.loveisrespect.org

Rape, Abuse & Incest National Network (RAINN) Hotline
1-800-656-HOPE (4673)

Asian and Hispanic Resources
Asian/Pacific Islander Domestic Violence Resource Project
202-464-4477
Adolante Familia 410-732-2176

Futures Without Violence - excellent resource for patients and providers, brochures, safety cards, fact sheets
www.FuturesWithoutViolence.org

House of Ruth Maryland - information and resources for patients
www.hruth.org, 410-889-7884 (hotline), 410-889-0840 (administrative office)

Look to End Abuse Permanently - information for health care providers on IPV assessment
http://www.leapsf.org

Maryland Coalition Against Sexual Assault (MCASA)
www.mcasa.org, 410-974-4507

Maryland Department of Health and Mental Hygiene (DHMH) – information to help health care providers assess for IPV
www.dhmh.maryland.gov/ipv

Maryland Health Care Coalition Against Domestic Violence (educational materials, reporting requirements)

Maryland Network Against Domestic Violence – information for patients, brochures, safety cards, fact sheets, data
www.mnadv.org/, 800-634-3577

Women’s Law Center of Maryland, Inc. - information about protective orders and other legal matters
www.wlcmd.org, 410-321-8761
REQUEST FOR CONFIDENTIAL COMMUNICATIONS

FORM

This form lets you choose where your health information gets sent after your health care visit. Right now, if you do not complete this form, your health information will be sent to the person who pays for the insurance you use. You can ask that the information be sent to a different address or by other means that only you will see. You can do this if you believe that giving your health information to the person paying for your insurance would put you in danger.

Before sending this form to your insurance company, you may wish to contact your insurance company to see if it permits a request to be taken over the phone or by email. If the insurance company requires a written request, complete this form and send it to your insurance company.

Information about Your Insurance Policy (Please Print)

This information is private and will only be used to help your insurance company identify your policy information. Please fill out as much information as you know.

Insurance Company Name: ____________________________________________

Your Name: ________________________________________________________

Date of Birth: _____________________________________________________

Name of the family member who is the policyholder (the person who is paying for the insurance): ___________________________________________

Address of family member who is the policyholder: ____________________________

Your member ID card number: _______________________________________

Group or account number on ID card: _______________________________

If your insurance company has a question about your request, is there a phone number or email address where they can reach you privately? If so, please provide the phone number or email address: ________________________________
REQUEST:

1. Please send any information about my health in the following manner: (such as street address, P.O. Box, or email address*):

2. I want my private health information to be sent to me privately because (choose one):
   - □ I believe I could be put in danger if all or part of my health information is sent to the policyholder.
   - □ Other (please give reason):

*Requests by some alternate manner may not be secure.

NOTE: When your insurance company approves your request, the approval will apply only to private messages from that insurance company. If you change insurance companies, you will need to make a new request to the new insurance company. After you send this form, check back with your insurance company to make sure your request has been processed and approved. It is important to know that until your request is approved, the insurance company may continue to send your private health information to the person who is paying for your health insurance.