

# WHY SCREEN FOR CHLAMYDIA?

*An Implementation Guide for Healthcare Providers*



**Early identification and treatment:**

**Reduces** pelvic inflammatory disease (PID)

**Reduces** infertility, ectopic pregnancy, and chronic pelvic pain

**Prevents** complications in newborns



*Why Screen for Chlamydia? An Implementation Guide for Healthcare Providers*, 2nd Edition was developed with assistance from the Provider Education Committee of the National Chlamydia Coalition. For a complete list of National Chlamydia Coalition members, visit <http://ncc.prevent.org/about/ncc-members>.

Aetna – Northeast & Mid-Atlantic Region	National Institute for Health Care Management Foundation
American Academy of Pediatrics	National Network of Prevention Training Centers
American College Health Association	Pennsylvania Department of Health
American College of Nurse-Midwives	Physicians for Reproductive Choice and Health
American College of Obstetricians and Gynecologists	Planned Parenthood Federation of America
California Department of Public Health	Society for Adolescent Health and Medicine
International Union against Sexually Transmitted Infections	The National Alliance to Advance Adolescent Health
Massachusetts Department of Public Health	The National Association of Nurse Practitioners in Women's Health
Michigan Department of Community Health	U.S. Department of Health and Human Services, Health Resources and Services Administration
National Association of Community Health Centers	U.S. Department of Health and Human Services, Office of Population Affairs

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Suggested Citation: Partnership for Prevention. *Why Screen for Chlamydia? An Implementation Guide for Healthcare Providers*. 2nd Edition. Washington, DC: Partnership for Prevention; 2012.

*Why Screen for Chlamydia? An Implementation Guide for Healthcare Providers* 2nd Edition was supported by the Division of STD Prevention, Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of Partnership for Prevention and do not necessarily represent the official views of CDC.



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**Access the resources in this guide at**  
<http://ncc.prevent.org/info/why-screen-linked-resources>

# Introduction to Chlamydia Screening

*Why Screen for Chlamydia?* offers healthcare providers the latest information and resources to:

- ▶ Improve delivery of chlamydia screening and retesting
- ▶ Make screening for and treating chlamydia routine practice
- ▶ Provide confidential care to adolescents
- ▶ Take a sexual history

The consequences of chlamydial infection fall predominately on females and their infants. Therefore, chlamydia

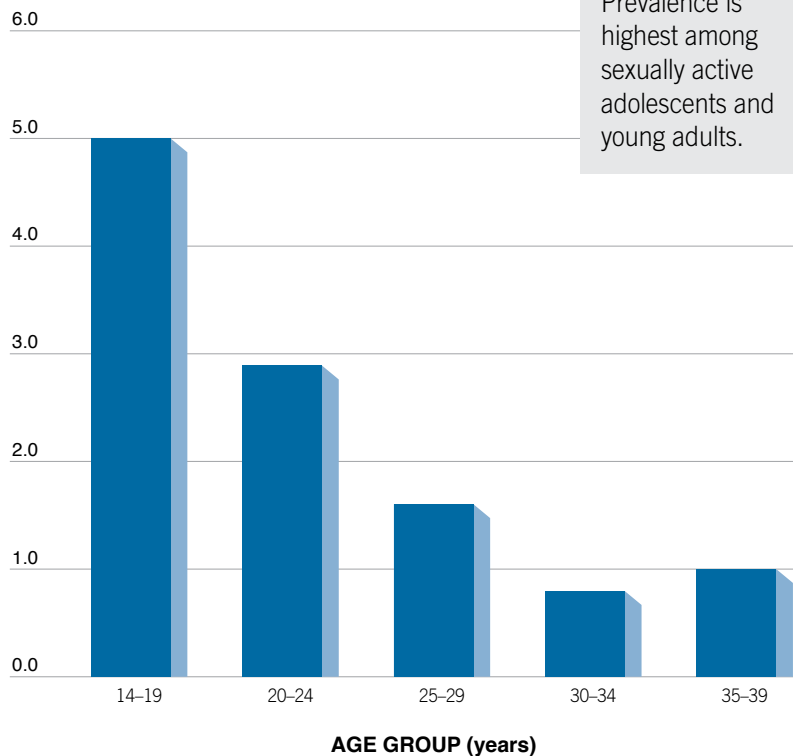
screening in females is an important measure of quality of care. It is a HEDIS (Healthcare Effectiveness Data and Information Set) measure and a performance measure that a health plan must report to gain or maintain National Committee for Quality Assurance (NCQA) accreditation. Health plans that will participate in state health insurance exchanges will also need to report information on chlamydia screening. It is also part of the core measure set for both the Children's Health Insurance Program and Medicaid.

## REASONS TO SCREEN YOUNG FEMALES FOR CHLAMYDIA

- ▶ Chlamydial infection is very common. Figure 1 illustrates that sexually active people aged 14-24 have about 3 times the chlamydia prevalence of sexually active adults aged 25-39.
- ▶ Over 1.3 million cases of chlamydia were reported in 2010, and it is estimated that 1 in 15 sexually active adolescent females has chlamydia.
- ▶ It is the leading preventable cause of tubal factor infertility in the U.S.
- ▶ Most cases are asymptomatic. Symptoms, if present, are often vague.
- ▶ Chlamydial infection can be easily detected from a self-collected vaginal swab or urine specimen using nucleic acid amplified tests (NAATs). A pelvic exam is not necessary.
- ▶ It is readily treatable with antibiotics.
- ▶ Screening reduces complications from untreated infection. The incidence of pelvic inflammatory disease (PID) could be reduced by up to 60% through screening programs.
- ▶ Annual medical costs of chlamydia, including treating sequelae, are estimated to be over \$700 million.
- ▶ Chlamydial infection facilitates transmission of HIV.
- ▶ Infection may cause pregnancy complications, such as early labor. Infants can be infected during birth, leading to conjunctivitis and pneumonia.
- ▶ The National Commission on Prevention Priorities ranks chlamydia screening as a high-value but underused clinical preventive service.

## 1 Burden of Infection

### PREVALENCE (%)



NHANES, National Health and Nutrition Examination Survey, 1999-2008 Sexual activity = "yes" response to "Have you ever had sex?" Sex = vaginal, anal, or oral sex

Centers for Disease Control and Prevention. CDC Grand Rounds: Chlamydia Prevention: Challenges and Strategies for Reducing Disease Burden and Sequelae, MMWR 2011, 60(12):370-373

## CHLAMYDIA SCREENING RECOMMENDATIONS

### Females aged 25 and younger.

Screen all sexually active females aged  $\leq 25$  annually. This recommendation is supported by the Centers for Disease Control and Prevention (CDC) and leading medical associations. The U.S. Preventive Services Task Force (USPSTF) recommends age 24 and younger. The HEDIS measure also uses age 24. For more information about the USPSTF's recommendation, see [Resource 1](#).

**Females over age 25.** Screen sexually active females over age 25 if they are at increased risk for infection. Risk factors include a history of chlamydial or other sexually transmitted infection,

new or multiple sex partners, and inconsistent condom use.

**Pregnant females.** Screen pregnant females at their first prenatal visit. Rescreen females age 25 and younger or those with a new sex partner or multiple partners in the third trimester. Retest females found to be infected with chlamydia in the first trimester within 3-6 months, preferably in the third trimester.

**Women Who Have Sex with Women (WSW).** Screen WSW according to the recommendations for females of their age and risk factor status.

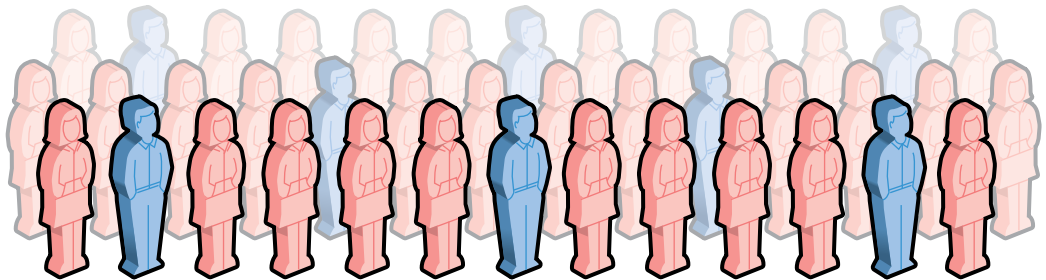
**Men Who Have Sex with Men (MSM).** Screen MSM at least annually for urethral infection (if engaged in insertive anal intercourse during the preceding year) and/or rectal

infection (if engaged in receptive anal intercourse during the preceding year). MSM engaging in high-risk behaviors should be screened every 3-6 months. Screen HIV+ MSM when they enter the health care system and then annually if they are sexually active. Screening for pharyngeal infection is not recommended.

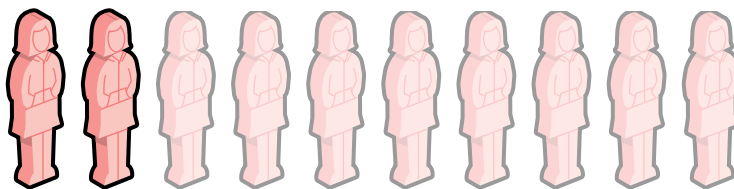
**Males.** Screen sexually active young men in clinical settings with high prevalence of chlamydia (e.g., correctional facilities and STD clinics) when resources permit and do not hinder chlamydia screening efforts in women.

## 2 Sequelae Of Untreated Chlamydial Infection in Females

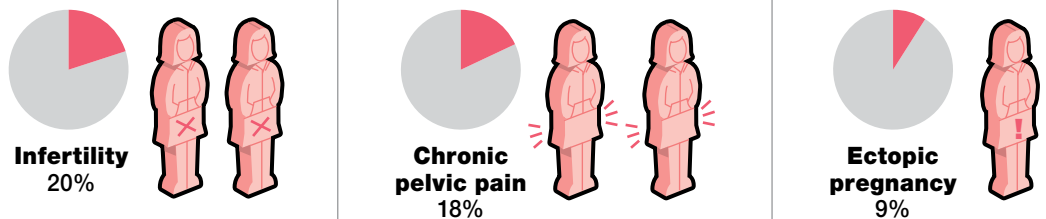
Estimated **2.8 million+** new cases each year



**PID** may develop in up to 20% of cases of untreated chlamydial infection.



Untreated PID may lead to:



Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2010. Haggerty CL, et al. Risk of sequelae after Chlamydia trachomatis genital infection in women. J Infect Dis. 2010;201 (Suppl 2):S134-S155.

# Testing for Chlamydial Infection

There are several tests to identify chlamydial infection. Urine, vaginal, endocervical, urethral, and rectal specimens can be tested. Urine testing is convenient and appropriate for many settings, especially those where pelvic exams are not routinely conducted. Females may also self-collect a vaginal specimen if they are not presenting for a pelvic exam (self-obtained vaginal specimens are FDA-cleared for collection in clinical settings). See the CDC's *Sexually Transmitted Disease Treatment Guidelines, 2010* for more information on testing ([Resource 2](#)).

▶ NAATs (nucleic acid amplified tests) are recommended for detecting chlamydia bacteria. NAATs are FDA-cleared for urine, urethral, vaginal, and endocervical samples. They are not FDA-cleared for testing rectal swab specimens. However, many laboratories have validated NAATs for such use. Some NAATs are approved for dual chlamydia – gonorrhea testing.

▶ Vaginal specimens, either clinician- or patient-collected, are preferred for screening asymptomatic females because the sensitivity is slightly higher than for urine specimens. Urine is the preferred specimen for screening males and may be used for screening females if it is more practical and easier to implement than collecting vaginal swabs. NAATs are most sensitive when used with a first-catch urine sample.

▶ Nucleic acid hybridization tests (DNA probe), direct fluorescent antibody test (DFA), and enzyme immunoassays (EIA) are less sensitive than NAATs and miss a larger number of infections. They are recommended when NAATs are unavailable.

▶ Contact your laboratory for detailed information on tests and procedures for handling specimens.

## SIGNS AND SYMPTOMS OF INFECTION

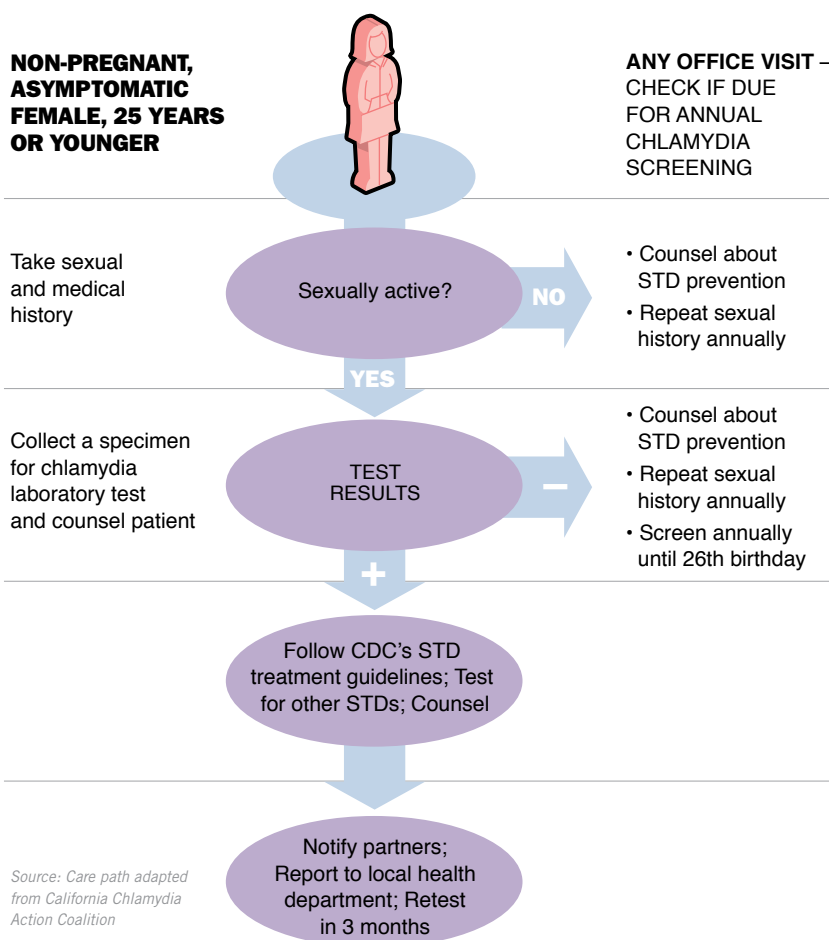
The following should prompt diagnostic testing for chlamydia:

- ▶ Abnormal vaginal discharge
- ▶ Dysuria (males and females)
- ▶ Vaginitis
- ▶ Cervicitis
- ▶ Post-coital bleeding
- ▶ Intermenstrual bleeding
- ▶ Painful intercourse
- ▶ PID symptoms, such as abdominal pain, low back pain, fever
- ▶ Penile itching, burning, or discharge
- ▶ Rectal pain, discharge, or bleeding (males and females)

## COMMUNICATING TEST RESULTS

Think about ways to confidentially communicate test results to your patients. One option is to have each patient complete a contact information form at check-in. Another option is to ask the patient to return to or call the office at a designated time when a

### 3 Chlamydia Screening Path



staff member can present test results. With adolescent patients, be sure to ask for cell phone numbers and the best times to call. Large practices may contract with companies that offer automated call-in services for patients to obtain test results. [Resource 3 \(page B-6\)](#) contains a sample form to establish ways to communicate test results.

## NOTIFYING PARTNERS

Sexual partners of a patient with diagnosed chlamydial infection should be notified to seek health care for testing and treatment. The patient, a member of your medical team, or a trained health department employee can notify partners. Check with your local health department to see if partner notification services are available for chlamydial infection and learn how providers can help. Even health departments with limited resources may prioritize certain patients for partner notification services, such as pregnant females, patients co-infected with HIV, those with recurring chlamydial infection, patients engaging in high-risk behaviors, and those concerned about the possibility of physical violence.

Inform your patient that if his/her sexual partners are not treated, he/she may be infected again. Explain that an untreated infection can spread to others and can cause health complications. Most patients prefer notifying their partners in person or by phone. Letter, email, and text message are other options. InSPOT offers anonymous e-cards that can notify partners to get tested ([Resource 4](#)). A sample letter providers can send is available at [Resource 5](#). [Resource 6](#) contains tips on conducting internet-based partner notification.

### Questions you might ask your patient are:

*“How would you like to let your partner(s) know that he/she needs to be tested for chlamydia?”*

*“Would you like to tell your partner(s) yourself or would you like me, someone from my office, or a trained specialist from the health department to?”*

*“How do you think your partner will react?”*

*“How are you feeling? People may feel embarrassed or angry when they’re diagnosed with an STD. If you are, we can talk about those feelings.”*

### If your patient chooses to notify his/her partner(s), remind him/her of these key points:

*“You have been exposed to chlamydia and could be infected.”*

*“You should seek medical care as soon as possible to get tested and treated.”*

*“Avoid all sexual contact for 7 days after you and your partner(s) begin treatment.”*

## EXPEDITED PARTNER THERAPY

Treating sexual partners is critical to preventing re-infection. When a partner exposed to chlamydia in the past 60 days is unable or unlikely to seek medical care, expedited partner therapy (EPT) is warranted. EPT is the practice of treating a sexual partner without that person being clinically assessed. It is supported by CDC, the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), the American Academy of Pediatrics (AAP), and the Society for Adolescent Health and Medicine (SAHM). EPT is recommended for treating the sexual

partners of heterosexual men and women, but not partners of men who have sex with men. EPT is also not recommended in cases of suspected child abuse, sexual assault or abuse, or in cases where the patient’s safety is questionable.

Many states allow EPT and it is possibly permissible in several others. You can find the legal status of EPT in your state at [Resource 7](#). If your state allows the use of EPT, find out the terms under which you must operate, who within your practice can provide EPT, and any liabilities.

Patient-delivered partner therapy is commonly used, where the patient gives the sex partner a prescription or medication along with educational materials and instructions for taking the medication. The partner is also urged to seek medical care. This is particularly important for female partners because of the risk of pelvic inflammatory disease (PID).

Barriers to implementing EPT may include potential drug allergies, operational issues related to electronic medical records (such as not having identifying information to link to a prescription) or payment of the partner’s medication, and liability concerns. If EPT is legal in your state, see if your state health department has guidelines to help you overcome these and other barriers.

# Treating Chlamydial Infection

Once a patient is diagnosed with chlamydia, treatment is usually quite simple. Recommended regimens are outlined below. Treatment should begin immediately after diagnosis to prevent complications and further transmission. More complete information is available in the CDC's *Sexually Transmitted Disease Treatment Guidelines, 2010* ([Resource 2](#)).

Instruct all patients who test positive for chlamydial infection to refrain from sexual intercourse for 7 days after taking a single-dose treatment, or until completing a 7-day course of treatment. They should also refrain from sexual intercourse until all sex partners have completed treatment.

## RECOMMENDED REGIMENS FOR NON-PREGNANT FEMALES AND MALES

*Azithromycin 1 g orally in a single dose*  
— OR —  
*Doxycycline 100 mg orally twice a day for 7 days*

A single dose of azithromycin, although more expensive than doxycycline, may be best for patients who are unlikely to comply with a 7-day course of antibiotics. Do a test-of-cure 3-4 weeks after completing treatment only if compliance is questionable, symptoms persist, or infection reoccurs.

## RECOMMENDED REGIMENS FOR PREGNANT FEMALES

*Azithromycin 1 g orally in a single dose*  
— OR —  
*Amoxicillin 500 mg orally three times a day for 7 days*

Doxycycline, ofloxacin, and levofloxacin are contraindicated during pregnancy. Limited data shows that azithromycin is safe and effective in pregnant females. Do a test-of-cure 3 weeks after completing treatment to ensure infection has been eradicated.

## ALTERNATIVE REGIMENS

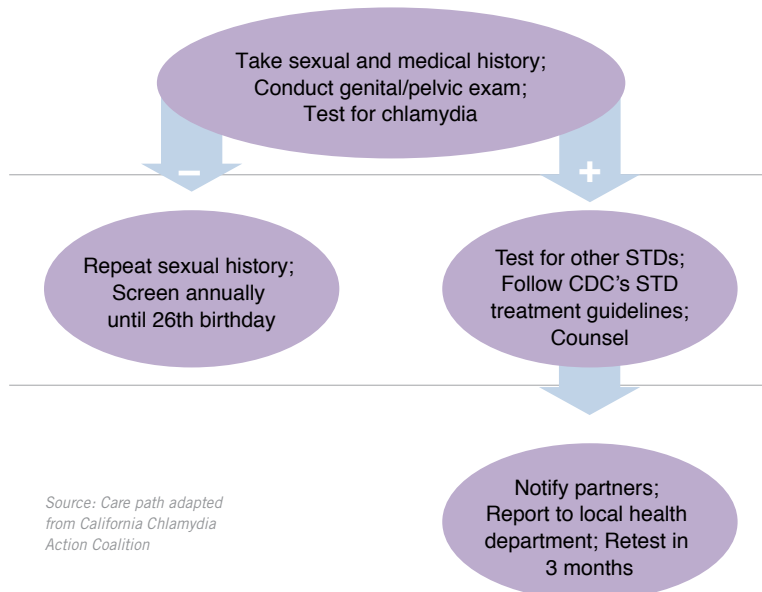
See CDC's *Sexually Transmitted Disease Treatment Guidelines, 2010* for complete information on alternative regimens.

## RETESTING AFTER TREATMENT

Repeat infections raise the risk of PID and other complications. Re-infection after treatment typically occurs because all sex partners were not treated or the patient initiates sexual activity with a new infected partner. CDC recommends that all males and females infected with chlamydia should be retested 3 months after treatment or at the next medical visit (within a 12 month period following initial treatment).

## 4 Diagnosis and Treatment Path

### UNCOMPLICATED SYMPTOMATIC, NON-PREGNANT FEMALE OR MALE



## REPORTING TO THE HEALTH DEPARTMENT

Every state mandates physicians, medical facilities, and/or laboratories to report cases of chlamydia to health departments. Reporting does not conflict with HIPAA because the law permits sharing protected health information for specified public health purposes. Reporting requirements vary by state. Your local health department can answer questions about how and when to report, and whether to report laboratory-confirmed or suspected cases of chlamydia. You can find your nearest health department at [Resource 8](#). Your state health department's web site may also include information on reporting communicable diseases.



# Taking a Sexual History

Screening for chlamydia starts with taking a patient's sexual history. A healthcare provider can collect this information as part of the patient's overall medical history or risk appraisal, or the patient can fill out forms in advance and a provider can review them. Including sexual behavior questions in a routine health behavior screening questionnaire allows providers to obtain valid patient information.

## TIPS FOR TAKING A SEXUAL HISTORY

- ▶ Establish rapport to make the patient feel comfortable.
- ▶ State that the discussion is confidential except if certain facts are revealed, such as if the patient discloses that he or she is a victim of abuse or is a danger to him or herself or someone else. Confidentiality is particularly important for adolescents, who are often reluctant to divulge sensitive information.
- ▶ Normalize the conversation by saying you ask all your patients about their sexual history.
- ▶ Think in terms of the five Ps:
  - ▷ Partners
  - ▷ Prevention of pregnancy
  - ▷ Protection from STDs
  - ▷ Practices
  - ▷ Past history of STDs
- ▶ Ask open-ended questions that are framed in a neutral, nonjudgmental manner.
- ▶ Do not make assumptions about a patient's sexual activities, gender identity, sexual orientation, or preferences.
- ▶ Stay away from clinical terms the patient may not understand.
- ▶ Allow the patient to ask questions.

Suggested questions to ask include the following:

*"Are you currently sexually active? Have you ever been?"*

*"Do you have sex with men, women, or both?"*

*"How many partners have you had in the past month? Six months? Lifetime?"*

*"Do you use any protection against STDs? If yes, what kind of protection? How often?"*

*"Are you using any birth control? If yes, what type? Would you like information about other types of birth control?"*

*"Have you ever had an STD? If yes, when?"*

## SPECIAL CONSIDERATIONS FOR TEENS

Broaching sensitive subjects like sexual behavior can be difficult for providers and teens. However, providers play an important role in identifying risk behaviors and educating adolescents about safe sex practices. It can take time to establish a rapport with your teen patients, but it is worth the effort.

You can incorporate taking a sexual history into a well or acute care visit, or when the teen presents for a sports, school, or camp physical. Always administer the sexual history in private without a parent present. Explain to parents that you spend a portion of each visit alone with your adolescent patients. This helps parents understand this is standard procedure and is not specific to their child. See [Resource 3 \(page A-16\)](#) for suggestions on how to ensure time alone with teen patients.

Adolescent health experts recommend the HEADSSS Assessment, a psychosocial screening

exam that includes a sexual history. It begins with topics such as home and education, then progresses to more sensitive ones, such as drugs, sexual activity and identity, depression, and suicide. [Resource 3 \(page B-9\)](#) contains an annotated version.

Office policies are useful for standardizing procedures. Consider developing an office policy that includes:

- ▶ the age at which sexual history taking begins (the AMA recommends starting at age 11)
- ▶ a plan that outlines how the sexual history will be taken, when in the visit it will occur, how parents are informed about the need for private time with the adolescent, and where the results will be discussed and by whom
- ▶ how the information collected is integrated into overall adolescent care
- ▶ how staff will be trained to take sexual histories of adolescent patients

## SEXUAL HISTORY RESOURCES

American Academy of Family Physicians – The Proactive Sexual Health History ([Resource 9](#))

California Chlamydia Action Coalition – Patient-Administered Sexual History Questionnaire ([Resource 10](#))

Centers for Disease Control and Prevention – A Guide to Taking a Sexual History ([Resource 11](#))

Group for the Advancement of Psychiatry – Taking a Sexual History with LGBT Patients ([Resource 12](#))

# Providing Services to Adolescents

Adolescents frequently need reproductive health services, but the healthcare system can make it difficult for teens to get the care they need. Many adolescents are worried their parents will find out they were tested for an STD. Other barriers include limited financial ability to pay for services or medications, a lack of transportation, inexperience with the healthcare system, and inconvenient office hours or locations.

## CONSENT TO SERVICES

Teens under the age of 18 can consent to receive STD services in all 50 States and the District of Columbia. Some states require that the teen be of a certain age (usually 12 or 14).

## CONFIDENTIALITY OF SERVICES

Confidentiality is of the utmost importance to many teens. The medical information of a minor who has consented to receive STD services is protected by a variety of laws. Although you strive to protect your patients' confidential information, there are circumstances when you may need to breach that trust. Some states allow providers the option of

notifying parents that a teen has received STD care. Providers are also required by state law to report suspected cases of physical or sexual abuse or neglect.

The insurance claims process can also breach an adolescent patient's confidentiality. Commercial health plans typically send the policyholder (usually a parent) an Explanation of Benefits (EOB) when someone on the policy obtains health services. The EOB identifies the patient, the type of service received, the date that service was received, and the provider. This practice virtually eliminates a teen's ability to seek care as an insured dependent without parental knowledge. Sending a teen's family the bill for a copayment may also breach confidentiality for your adolescent patient.

Other ways to help ensure your adolescent patients' confidentiality are:

- ▶ Offer teens the option of paying out-of-pocket, perhaps at a reduced rate. Check with your insurers' terms of agreement to see if this is permitted.
- ▶ Notify the insurance company that the services provided are confidential

and are not to be disclosed. See [Resource 13](#) for a sample letter.

- ▶ See if your state allows you to tell your patient that an EOB or laboratory bill can be sent to a different address.
- ▶ Refer patients to Title X-funded clinics, which do not send EOBs. See [Resource 14](#) to find nearby Planned Parenthood clinics and [Resource 15](#) to locate clinics providing STD services.

## ADOLESCENT HEALTHCARE RESOURCES

- ▶ Adolescent Health Working Group – Adolescent Health Care 101: Provider Toolkit ([Resource 3](#))
- ▶ American College of Obstetricians and Gynecologists – Toolkit for Teen Care, Second Edition ([Resource 16](#))

## CODING

Under the Patient Protection and Affordable Care Act (PPACA), females under age 24 and females over age 25 at increased risk can be screened for chlamydia with no cost-sharing when provided by in-network providers. To avoid cost-sharing, screening must be the primary purpose of the visit. The CPT modifier 33 aids in correctly coding for preventive services that fall under the PPACA and have no cost-sharing. The PPACA does not cover screening for males and

grandfathered health plans are exempt from the no cost-sharing requirement.

- ▶ The Society for Health and Adolescent Medicine has several resources related to coding and protecting adolescents' confidentiality. You can find these at [Resource 17](#).
- ▶ The AMA has developed a coding guide for NAAT testing of non-genital chlamydial and gonorrheal infections ([Resource 18](#)).

## 5 Teen Friendly Office Tips

These office practices and suggestions can be adapted to any outpatient medical setting. Choose the ones that work in your office.

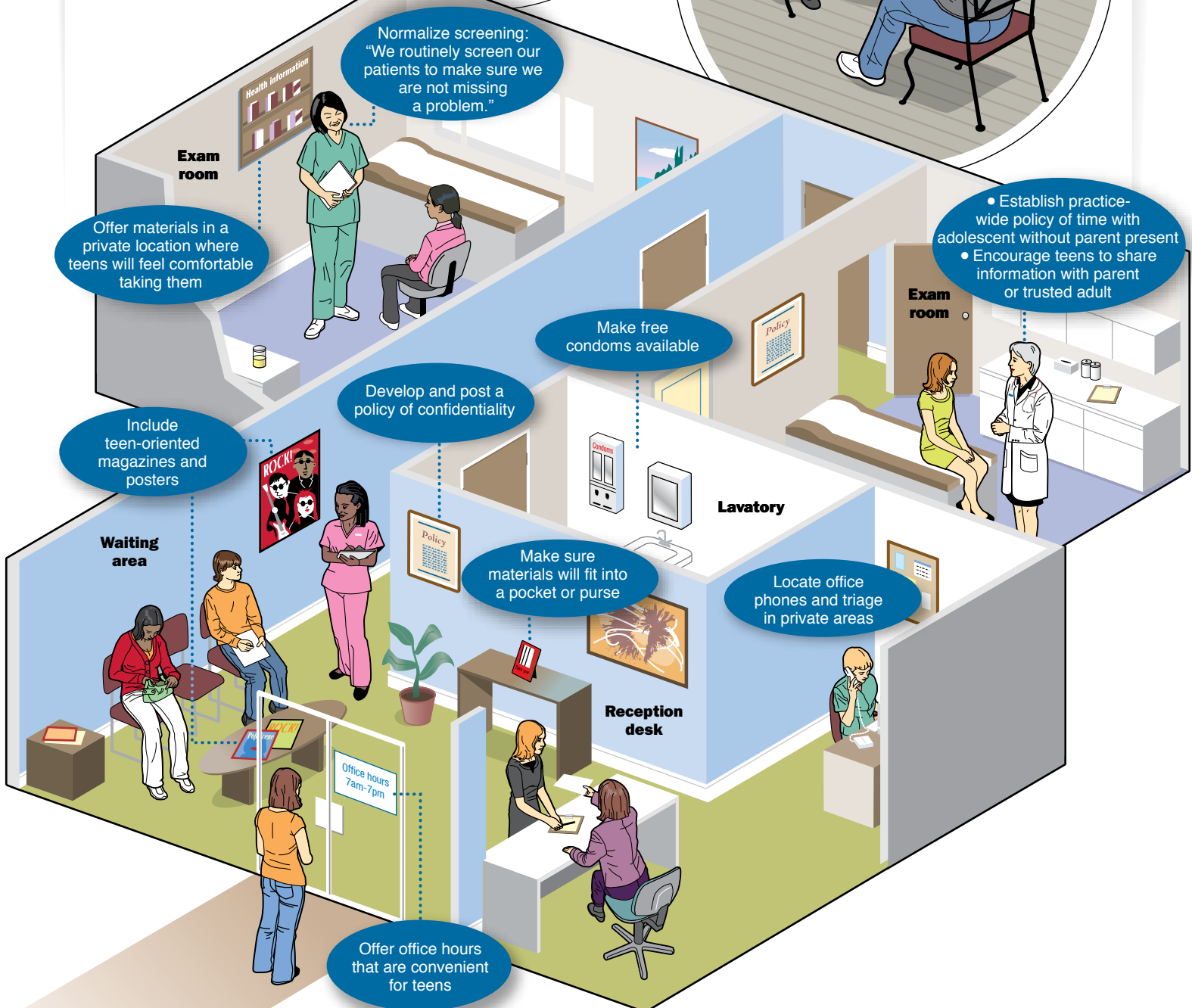


- Report lab results
- Prescribe treatment
- Discuss partner notification

- Partner must seek health care
- No sexual contact until seven days after treatment begins



### Partner Notification



# Putting Screening into Practice

Simple alterations to your office procedures can increase how often you screen patients for chlamydia. Suggested changes are outlined below.

## **PRIORITIZE STDs AND SCREENING**

- ▶ Designate someone in your office to lead your effort to increase chlamydia screening. Leadership is necessary to ensure changes are made that will boost your screening rate.
- ▶ Make sure your office staff understands that chlamydial infection is serious and prioritizes suspected cases. Staff members should know the screening recommendations for different patient populations.

## **DETERMINE AN APPROPRIATE SCREENING METHOD**

- ▶ Choose which specimen to collect to screen your patients. Vaginal specimens, either patient- or clinician-obtained, are preferred for screening asymptomatic females. Urine may also be obtained for both males and females. Patients prefer self-collected vaginal swab- or urine-based screening because it is less invasive than collecting an endocervical or urethral swab specimen. Adolescent females are particularly good candidates for self-collected vaginal swab or urine-based screening because they do not need pelvic exams if they are asymptomatic.
- ▶ Collect a swab sample if a pelvic exam is indicated, if testing for rectal infection, or if urine-based or self-collected vaginal swab screening is infeasible. One cervical specimen can test for both cervical cancer and chlamydia. When a Pap test is not indicated, female patients can also self-collect a vaginal specimen.

## **IMPLEMENT PRACTICE SYSTEMS TO INTEGRATE CHLAMYDIA SCREENING INTO ALL VISITS**

- ▶ Take every patient's sexual history. This normalizes discussing sexual behavior and allows providers to identify issues that jeopardize a patient's sexual health. For adolescents, take a sexual history at every visit, not only well visits.
- ▶ Systematize the collection of a specimen from patients. If implementing urine-based screening, consider asking all your adolescent and young adult patients to leave a urine sample before entering the exam room. Test only the specimens of those patients identified during the sexual history as being sexually active or due for screening. Post instructions on how patients should properly collect a vaginal or urine sample to avoid contamination.
- ▶ Use protocols, standing orders, reminder systems, and office policies to streamline office procedures. These tools can ensure that screening opportunities are not missed by outlining who is responsible for certain tasks, when to do those tasks, and how. Reminders (including rescreening reminders) may be built into an electronic medical records system, or could be as simple as stickers and flowcharts. Develop policies for taking a sexual history, confidentiality, and time alone with adolescent patients and be sure that all staff know and follow them.

## **EDUCATE PROVIDERS AND PATIENTS ABOUT CHLAMYDIA AND OTHER STDs**

- ▶ Offer continuing education courses to the providers in your medical practice. See [Resource 19](#) for a list of online continuing education courses.
- ▶ Provide patient education materials about preventing STDs in your waiting room and in each exam room. You could also direct patients to reputable web sites with consumer-oriented health information, such as Medline Plus, American Sexual Health Association, Mayo Clinic, and the CDC.
- ▶ Contact your state or local health department for training resources.

# Resources

**Resource 1:** U.S. Preventive Services Task Force. Screening for Chlamydial Infection.  
<http://snipurl.com/whyscreen1>.

**Resource 2:** Centers for Disease Control and Prevention. Sexually Transmitted Disease Treatment Guidelines, 2010.  
<http://snipurl.com/whyscreen2>.

**Resource 3:** Adolescent Health Working Group. Adolescent Health Care 101: The Basics – CA Edition.  
<http://snipurl.com/whyscreen3>.

**Resource 4:** InSpot. Tell them e-cards.  
<http://snipurl.com/whyscreen4>.

**Resource 5:** Massachusetts Department of Public Health. Prevention and Management of Chlamydial Infections in Adolescents: A Toolkit for Clinicians.  
<http://snipurl.com/whyscreen5>.

**Resource 6:** National Coalition of STD Directors. Guidelines for Internet-based Partner Services.  
<http://snipurl.com/whyscreen6>.

**Resource 7:** Centers for Disease Control and Prevention. Legal Status of Expedited Partner Therapy (EPT).  
<http://snipurl.com/whyscreen7>.

**Resource 8:** National Association of County and City Health Officials. Directory of Local Health Departments (LHD Index).  
<http://snipurl.com/whyscreen8>.

**Resource 9:** American Academy of Family Physicians. The Proactive Sexual Health History.  
<http://snipurl.com/whyscreen9>.

**Resource 10:** California Chlamydia Action Coalition. Patient-Administered Sexual History Questionnaire.  
<http://snipurl.com/whyscreen10>.

**Resource 11:** Centers for Disease Control and Prevention. A Guide to Taking a Sexual History.  
<http://snipurl.com/whyscreen11>.

**Resource 12:** Group for the Advancement of Psychiatry. Taking a Sexual History with LGBT Patients.  
<http://snipurl.com/whyscreen12>.

**Resource 13:** American Civil Liberties Union. Guide to Protecting Teen's Confidentiality under Federal Medical Privacy Regulations.  
<http://snipurl.com/whyscreen13>.

**Resource 14:** Planned Parenthood. Find a Health Center.  
<http://snipurl.com/whyscreen14>.

**Resource 15:** Centers for Disease Control and Prevention. National HIV and STD Testing Resources.  
<http://snipurl.com/whyscreen15>.

**Resource 16:** American College of Obstetricians and Gynecologists. Toolkit for Teen Care Second Edition.  
<http://snipurl.com/whyscreen16>.

**Resource 17:** Society for Adolescent Health and Medicine. Clinical Care Resources, Billing and Coding.  
<http://snipurl.com/whyscreen17>.

**Resource 18:** American Medical Association. Coding Guide for Nucleic Acid Amplification Testing to Diagnose Non-genital Infections with Gonorrhea and Chlamydia.  
<http://snipurl.com/whyscreen18>.

**Resource 19:** Centers for Disease Control and Prevention. Continuing Education Online.  
<http://snipurl.com/whyscreen19>.

## Additional Information about STDs and Sexual Health

**American Sexual Health Association**  
<http://www.ashastd.org>

**Centers for Disease Control and Prevention**  
<http://www.cdc.gov/std>

**Get Yourself Tested**  
<http://www.itsyoursexlife.com/gyt/>

**National HIV and STD Testing Resources**  
<http://hivtest.cdc.gov/STDTesting.aspx>

**Mayo Clinic**  
<http://www.mayoclinic.org>

**Medline Plus**  
<http://www.nlm.nih.gov/medlineplus/sexuallytransmitteddiseases.html>

**Planned Parenthood**  
<http://www.plannedparenthood.org>

