

Confidential Notification of Chlamydia and Gonococcal Infections
Please complete for all laboratory confirmed and suspect (clinical) cases.

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name: Location: Attending Physician or Nurse: Address: Phone number:	FOR PUBLIC HEALTH OFFICE USE ONLY: Service Area: Date Received: Panorama Client ID: Panorama Investigation ID:
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B) CLIENT INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	Place of Employment/School:
Health Card Province: Health Card Number (PHN):	Gender Identity: <input type="checkbox"/> Transgender Male-to-female <input type="checkbox"/> Transgender Female-to-male <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Other:	Email Address:
Address: FN Community:	Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description	Phone: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace: <input type="checkbox"/> Alternate Contact: Relationship:
Is case pregnant? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, a Test of Cure is recommended: Please provide with a Lab Requisition		
Is case HIV positive? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, does the client disclose status to partners? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
Is case HB positive? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, does the client disclose status to partners? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		

C) INFECTION INFORMATION

Infection Reported: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhoea Classification: Classification Date: YYYY / MM / DD <input type="checkbox"/> Laboratory Confirmed <input type="checkbox"/> Suspect (clinical) (<i>indicate Signs, Symptoms, Syndromes – Section E</i>) <input type="checkbox"/> Contact to a case	LAB TEST - Date specimen collected: YYYY / MM / DD
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D) PRESENTATION (SITES)

Site: Genital Extra-genital: Pharyngeal Rectal Other - _____ Perinatally acquired (first 28 days of life)

E) SIGNS, SYMPTOMS, SYNDROMES (only required for Suspect cases)

Description	No	Yes - Date of onset	Description	No	Yes - Date of onset
Asymptomatic		YYYY / MM / DD	Pain – abdominal		YYYY / MM / DD
Bleeding - vaginal – abnormal		YYYY / MM / DD	Pain – deep pelvic (dyspareunia)		YYYY / MM / DD
Cervicitis (strawberry/friable cervix, cervical discharge)		YYYY / MM / DD	Urethritis (urethra discharge, dysuria)		YYYY / MM / DD
Discharge - vaginal		YYYY / MM / DD	Other:		YYYY / MM / DD
Epididymitis (<i>Gonococcal infection only</i>)		YYYY / MM / DD			

F) TREATMENT

Date treated: YYYY / MM / DD **Treated By:** _____ **Direct Observed Therapy (DOT)** Yes No
 Azithromycin 1gm Cefixime 800 mg Amoxicillin 500 mg tid x 7d Gentamicin 240 mg IM
 Azithromycin 2gm Ceftriaxone 250 mg IM Erythromycin 333mg ii tid x 7d **or** other dosage:
 Other Medications: _____ Doxycycline 100mg bid x 7d **or** other dosage:

G) RISK FACTORS (Please complete all Risk Factors in the 3 months prior to appointment)

DESCRIPTION	Yes	N, NA, U	DESCRIPTION	Yes	N, NA, U
Goods provided (food, shelter, money or drugs) in exchange for sex.			Goods received (food, shelter, money or drugs) in exchange for sex.		
MSM (men who have sex with men)			Unknown/anonymous partner		
More than 2 sexual partners in past 3 months			Travel – Outside of Canada (<i>Add'l Info.</i>)		
E-partnering (internet or apps for sex) (<i>Add'l Info</i>)					

Confidential Notification of Sexual Contacts Of persons diagnosed with Chlamydia or Gonococcal Infections

(include all sexual contacts in the last 60 days or the last sexual partner if >60 days); use additional sheets if > 2 contacts

H) INFECTIOUS PERIOD (INCLUDE DATES FOR CONTACT TRACING)

From: YYYY / MM / DD	to	YYYY / MM / DD
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I) UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts: _____ (the number of individuals that the individual cannot name)

SEXUAL CONTACT INFORMATION #1

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Workplace: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Alternate phone: Relationship:	e-mail Address:	
Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description		
Street Address or FN Community (Primary Home):		
Online Names: Site/Service:	User name:	Place of Employment/School:
Exposure Dates: 1st YYYY / MMM / DD to YYYY / MMM / DD		Is contact pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Exposure Type: <input type="checkbox"/> Vaginal/penile <input type="checkbox"/> Oral <input type="checkbox"/> Anal <input type="checkbox"/> Delivery/Perinatal		Is this person positive for an STI? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Will the testing Physician/Nurse follow-up this contact? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date contact notified: YYYY / MMM / DD Was treatment given? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____ Will index case be notifying contact <input type="checkbox"/> Yes <input type="checkbox"/> No		HIV Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hepatitis B Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Comments:

SEXUAL CONTACT INFORMATION #2

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Workplace: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Alternate phone: Relationship:	e-mail Address:	
Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description		
Street Address or FN Community (Primary Home):		
Online Names: Site/Service:	User name:	Place of Employment/School:
Exposure Dates: 1st YYYY / MMM / DD to YYYY / MMM / DD		Is contact pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Exposure Type: <input type="checkbox"/> Vaginal/penile <input type="checkbox"/> Oral <input type="checkbox"/> Anal <input type="checkbox"/> Delivery/Perinatal		Is this person positive for an STI? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Will the testing Physician/Nurse follow-up this contact? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date contact notified: YYYY / MMM / DD Was treatment given? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____ Will index case be notifying contact <input type="checkbox"/> Yes <input type="checkbox"/> No		HIV Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hepatitis B Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Comments: