Confidential Notification of Chlamydia and Gonococcal Infections

Please complete for all laboratory confirmed and suspect (clinical) cases.

PANORAMA

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name: Location: Attending Physician or Nurse: Address:	***FOR PUBLIC HEALTH OFFICE USE ONLY:*** **Service Area:** **Date Received:** **Panorama Client ID:** **Panorama Investigation ID:**

B) CLIENT INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: Age:	Gender: ◯ Male ◯ Female ◯ Unknown ◯ Other Gender Identity: ◯ Transgender Male-to-female ◯ Transgender Female-to-male ◯ Undifferentiated ◯ Other:	Place of Employment/School:
Health Card Province: SK Health Card Number (PHN):		Email Address:
Address: FN Community: Address Type: ◯ No fixed ◯ Postal Address ◯ Primary Home ◯ Temporary ◯ Legal Land Description		Phone: Primary Home: Mobile contact: Workplace: Alternate Contact: Relationship:

Is case pregnant? ◯ Unknown ◯ No ◯ Yes If Yes, a Test of Cure is recommended: Please provide with a Lab Requisition

Is case HIV positive? ◯ Unknown ◯ No ◯ Yes If Yes, does the client disclose status to partners? ◯ No ◯ Yes ◯ Unknown

Is case HB positive? ◯ Unknown ◯ No ◯ Yes If Yes, does the client disclose status to partners? ◯ No ◯ Yes ◯ Unknown

C) INFECTION INFORMATION

Infection Reported: ☐ Chlamydia ☐ Gonorrhea **Classification:** **Classification Date**: ☐ Laboratory Confirmed ☐ Suspect (clinical) *(indicate Signs, Symptoms, Syndromes – Section E)* ☐ Contact to a case	**LAB TEST** **Date specimen collected:**

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	☐		Pain – abdominal	☐	
Bleeding - vaginal – abnormal	☐		Pain – deep pelvic (dyspareunia)	☐	
Cervicitis (strawberry/friable cervix, cervical discharge)	☐		Urethritis (urethra discharge, dysuria)	☐	
Discharge - vaginal	☐		Other:	☐	
Epididymitis (*Gonococcal infection only*)	☐				

F) TREATMENT

Date treated: Treated By: Direct Observed Therapy (DOT) ◯ Yes ◯ No

☐ Azithromycin ☐ 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
E-partnering (internet or apps for sex) (*Add'l Info)*	◯	◯	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 (*Add'l Info.)*	◯	◯
Goods **provided** (food, shelter, money or drugs) in exchange for sex.	◯	◯			

H) INFECTIOUS PERIOD (INCLUDE DATES FOR CONTACT TRACING)

From: To:

I) UNKNOWN/ANONYMOUS CONTACTS

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

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

SEXUAL CONTACT INFORMATION #1

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

SEXUAL CONTACT INFORMATION #2

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