

Communicable Disease Reporting Form

Chlamydia Gonorrhoea

All information requested below is required.

Please complete and return to SMDHU by fax to (705)-733-7738

Reported By	Form Completed On		
Health Care Provider (HCP):	yy/mm/dd		
Family HCP (if different):	Phone #:		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Phone #:</td> <td style="width: 50%; border: none;">Phone #:</td> </tr> </table>		Phone #:	Phone #:
Phone #:	Phone #:		
Patient Demographics			
Name: _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X <small style="margin-left: 100px;">last name, first name</small> <small style="margin-left: 150px;">yyyy/mm/dd</small>			
Address: _____ Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Text <input type="checkbox"/> Other _____ _____ Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Text <input type="checkbox"/> Other			
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____			
Reason for Testing			
<input type="checkbox"/> Routine screen <input type="checkbox"/> Contact of case <input type="checkbox"/> Sexual assault <input type="checkbox"/> Prenatal screen Due date: _____ <input type="checkbox"/> Resistance suspected <input type="checkbox"/> Resistance confirmed <input type="checkbox"/> Therapeutic abortion <input type="checkbox"/> Symptomatic Onset Date: _____			
Tick all that apply <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Rectal pain <input type="checkbox"/> Abnormal vaginal bleeding <input type="checkbox"/> Nausea <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Scrotal pain <input type="checkbox"/> Discharge, purulent <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary Difficulty <input type="checkbox"/> Urethral irritation <input type="checkbox"/> Fever <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Asymptomatic			
<small>NOTE: Rectal and/or pharyngeal NAAT testing is recommended with receptive exposures at these sites in the following individuals: MSM, sex trade workers and their sexual contacts, contacts of a gonorrhoea case or based on clinical evaluation of symptoms or sexual behaviors</small>			
Risk Factors			
Tick all that apply <input type="checkbox"/> No condom/barrier used <input type="checkbox"/> Anonymous sex <input type="checkbox"/> Condom/barrier breakage <input type="checkbox"/> Sex trade worker <input type="checkbox"/> New contact in past 2 months <input type="checkbox"/> Sex with sex trade worker <input type="checkbox"/> > 1 partner in last 6 months (#____) <input type="checkbox"/> Met partner through internet <input type="checkbox"/> Sex with opposite sex <input type="checkbox"/> Judgement impaired by alcohol/drugs <input type="checkbox"/> Sex with same sex <input type="checkbox"/> Pregnant <input type="checkbox"/> Sex with trans <input type="checkbox"/> HIV positive <input type="checkbox"/> If HIV positive, taking Antiretroviral treatment (ART)			
Health Teaching			
Patient has been informed of their infection and provided with the following health teaching: <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> Encouraged to use condom/barriers Advised to abstain from sexual activity for 7 days following treatment of patient and sex partner(s) Informed that all sex partners within the last 60 days need to be notified. If none in last 60 days, then last sex partner(s) Advised to rescreen in 3 months for chlamydia cases, in 6 months for gonorrhoea cases and consider STI bloodwork 			

Please complete page 2

Partner Information

Number of partners in the last 60 days: _____

- Patient to notify partner(s)
 Health Care Provider to test and treat partner(s)
 Untraceable partner(s): anonymous partner(s) or insufficient contact information
* Patient requests that Public Health notify partner(s) anonymously and confidentially

* **Partner is pregnant** Yes No **Patient or partner: has delivered baby in last 90 days** Yes No N/A

* Enter contact information below

Name	M/F/X	Address	Phone #	Age/DOB	Other

N.B. If you would like free STI medications for this patient please call (705) 721-7520 x 8376 or 1 877 721-7520 x 8376

Chlamydia Treatment

First line:

- Doxycycline 100 mg PO BID x 7 days or
 Azithromycin 1 g PO single dose

Tx Date: _____

- Medication provided Rx provided

Alternate Therapeutic Treatment:

Test of Cure required

For alternate treatment options, refer to the Canadian Guidelines on Sexually Transmitted Infections, Chlamydia chapter

Tx: _____

Tx Date: _____

Gonorrhea Treatment

First line:

- Ceftriaxone 250 mg IM + Azithromycin 1 g PO single dose to be administered/taken same day

Tx Date: _____

- Medication provided/Administered Rx provided

Alternate Therapeutic Treatment:

Use only when first-line is not possible.

For alternate treatment options, refer to Public Health Ontario, Ontario Gonorrhea Testing and Treatment Guide, 2nd Edition

Tx: _____

Tx Date: _____

Please indicate reasons for alternate treatment used:

- Allergic to first line Medication contraindication(s)
 Refusal of IM injection Other: _____
 First line unavailable

Test of Cure (TOC)

Patient advised to have TOC Yes No

TOC required when:

- first line treatment not used
- patient is pregnant
- compliance is uncertain
- re-exposure to untreated partner
- there is gonorrhea infection
- suspected/confirmed treatment failure for patient and/or partner(s)
- reduced susceptibility to cephalosporins reported for patient/partner(s)
- PID or disseminated infection
- therapeutic abortion
- child ≤ 12 years of age

Chlamydia: TOC by **NAAT** (swab or urine) taken **3-4** weeks post treatment

Gonorrhea: **Culture** is preferred for TOC (particularly if clinical failure or resistance to treatment is suspected), taken **3-7** days post treatment.

TOC by **NAAT** (swab or urine) taken **2-3** weeks post treatment

*Genetic material may persist longer than 4 weeks and therefore must be considered when interpreting positive TOC results

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