

CHLAMYDIA / GONORRHEA Infectious Disease Reporting Form

All information requested below is required.
Please complete and return to SMDHU by fax to (705) 733-7738

Reported by _____ **Form Completed on** yyyy/mm/dd

Health Care Provider (HCP): _____ Phone #: _____
Family HCP (if different): _____ Phone #: _____

Patient Demographics

Name: _____ DOB: _____ M F X
last name, first name *yyyy/mm/dd*
Address: _____ Phone: _____ Home Cell Text Other
Primary Language: English French Other: _____

Reason for Testing

- Routine screen Contact of case Sexual assault Prenatal screen **Due Date:** _____
 Resistance suspected Resistance confirmed Therapeutic abortion
 Asymptomatic Symptomatic **Onset date:** _____
 If Symptomatic, Select all that apply
 Abdominal pain Rectal pain Abnormal vaginal bleeding
 Nausea Painful intercourse Scrotal pain Discharge, purulent
 Urinary frequency Urinary difficulty Urethral irritation Fever
 Other: _____

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

Risk Factors (Select all that apply)

- No condom/barrier used Sex trade worker Sex with opposite sex
 Condom/barrier breakage Sex with sex trade worker Sex with same sex
 New contact in past 2 months Met partner through internet Sex with trans
 >1 partner in last 6 months (#____) Judgement impaired by alcohol/drugs Anonymous sex
 HIV positive If HIV positive, taking Antiretroviral treatment (ART)

Chlamydia Treatment (Select one)

- First-line Treatment:**
 Doxycycline 100 mg PO BID x 7 days **or**
 Azithromycin 1 g PO single dose
Tx Date: _____

For alternate treatment options, refer to the [Public Agency of Canada Guidelines on Sexually Transmitted Infections, Chlamydia chapter](#)
- If alternate treatment is provided, please provide details below
- Only use when first-line treatment is not possible

Tx: _____
Tx Date: _____

Gonorrhoea Treatment (Select one)

- First-line Treatment:**
 Ceftriaxone 500 mg IM single dose
Tx Date: _____

For alternate treatment options, refer to [Public Agency of Canada Guidelines on Sexually Transmitted Infections, Gonorrhoea chapter](#)
- If alternate treatment is provided, please provide details below
- Only use when first-line treatment is not possible

Tx: _____
Tx Date: _____

If you would like free STI medications for this patient please call (705) 721-7520 x 8632 or 1 877 721-7520 x 8632

Continue on Page 2...

Health Teaching – Please advise the patient of the following information:

- Use condom/barriers
- Abstain from sexual activity for 7 days following treatment of patient and their sex partner(s)
- Rescreen in 3 months for chlamydia cases, in 6 months for gonorrhea cases
- Consider other STBBI bloodwork/testing
- Notify all sexual partners within the last 60 days. If none in last 60 days, then last sex partner(s)

Chlamydia Test of Cure (TOC):

- Recommended when first-line treatment is not used
- Recommended when the patient is pregnant
- Recommended when compliance is uncertain
- Recommended when re-exposure occurs
- Recommended when persistent symptoms occur
- NAAT is recommended 3-4 weeks post-treatment

Gonorrhea Test of Cure (TOC):

- Recommended for ALL positive cases
- Culture is the preferred method using the charcoal swab
- Culture is recommended 3 to 7 days post-treatment
- If culture is not available, NAAT is recommended 3-4 weeks post-treatment

Partner/Contact Notification – It is the patient’s responsibility to notify all known contacts within the last 60 days

If patient is requesting Public Health notify their partner(s), anonymously and confidentially, please add contact information in table below or direct patient to contact SMDHU at 1-877-721-7520 extension 8632.

*****Contacts meeting the following criteria MUST be included below and followed up by public health.**

- All contacts who are pregnant
- All contacts who are under 16 years old (including infants)
- All contacts of cases who are under 16 years old
- All contacts of cases that are co-infected with HIV and have an unknown viral load
- All contacts of cases whose lab (culture) shows antibiotic resistance to Cefixime (Suprax), Ceftriaxone or Azithromycin

Name	DOB/Age	Male/Female/ Other	Contact information (phone number, address, email, online profile username)

Physician or Nurse Practitioner signature _____ Date signed _____