

Confidential Notification of Chlamydia and Gonococcal Infections

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: ☐ Male ☐ Female ☐ Unknown ☐ Other	Place of Employment/School:
Health Card Province: Health Card Number (PHN):	Gender Identity: ☐ Transgender Male-to-female ☐ Transgender Female-to-male ☐ Undifferentiated ☐ Other:	Email Address:
Address: FN Community:		Phone: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace: ☐ Alternate Contact: Relationship:
Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description		
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: YYYY / MM / DD ☐ Laboratory Confirmed ☐ Suspect (clinical) (indicate Signs, Symptoms, Syndromes – Section E) ☐ 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 ☐ Conjunctivitis ☐ Disseminated GC ☐ Perinatally acquired (first 28 days of life)

E) SIGNS & SYMPTOMS

Description	No	Yes - Date of onset	Description	No	Yes - Date of onset
Asymptomatic		YYYY / MM / DD	Symptomatic (enter earliest symptom date)		YYYY / MM / DD
Complete for Perinatally Acquired or Disseminated Gonorrhea					
Arthritis, Polyarthralgia		YYYY / MM / DD	Meningitis		YYYY / MM / DD
Bacteremia		YYYY / MM / DD	Skin lesions – petechial or pustular		YYYY / MM / DD
Conjunctivitis		YYYY / MM / DD	Tenosynovitis		YYYY / MM / DD
Endocarditis		YYYY / MM / DD	Other (specify)		YYYY / MM / DD

F) TREATMENT

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

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 (Add'l Info.)		
E-partnering (internet or apps for sex) (Add'l Info)					

Confidential Notification of Sexual Contacts of People with Chlamydia or Gonorrhea Case Name: _____

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

Page ____ of ____

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: ☐ Male ☐ Female ☐ Unknown ☐ Other	
Phone #: ☐ Primary Home: ☐ Workplace: ☐ Mobile contact: ☐ Alternate phone: Relationship:		e-mail 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 YYYY / MMM / DD to YYYY / MMM / DD		Is contact pregnant? ☐ Yes ☐ No ☐ Unknown Is this person positive for an STI? ☐ Yes ☐ No ☐ Unknown
Exposure Type: ☐ Vaginal/penile ☐ Oral ☐ Anal ☐ Delivery/Perinatal		HIV Positive: ☐ Yes ☐ No ☐ Unknown Hepatitis B Positive: ☐ Yes ☐ No ☐ Unknown
Will the testing Physician/Nurse follow-up this contact? ☐ Yes ☐ No If yes, date contact notified: YYYY / MMM / DD Was treatment given? ☐ Yes ☐ No Specify: _____ Will index case be notifying contact ☐ Yes ☐ No		Comments:

SEXUAL CONTACT INFORMATION #2

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other	
Phone #: ☐ Primary Home: ☐ Workplace: ☐ Mobile contact: ☐ Alternate phone: Relationship:		e-mail 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 YYYY / MMM / DD to YYYY / MMM / DD		Is contact pregnant? ☐ Yes ☐ No ☐ Unknown Is this person positive for an STI? ☐ Yes ☐ No ☐ Unknown
Exposure Type: ☐ Vaginal/penile ☐ Oral ☐ Anal ☐ Delivery/Perinatal		HIV Positive: ☐ Yes ☐ No ☐ Unknown Hepatitis B Positive: ☐ Yes ☐ No ☐ Unknown
Will the testing Physician/Nurse follow-up this contact? ☐ Yes ☐ No If yes, date contact notified: YYYY / MMM / DD Was treatment given? ☐ Yes ☐ No Specify: _____ Will index case be notifying contact ☐ Yes ☐ No		Comments: