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:**

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: 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**: 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

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 **or** 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*); use additional sheets if > 2 contacts

H) INFECTIOUS PERIOD (INCLUDE DATES FOR CONTACT TRACING)

From: YYYY / MM / DD to YYYY / MM / DD

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**:	