Government of Saskatchewan

PANORAMA

Confidential Notification of Chlamydia and Gonococcal Infections

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

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name:	***FOR PUBLIC HEALTH OFFICE USE ONLY:***
Location:	**Service Area:**
Attending Physician or Nurse:	**Date Received:**
Address:	**Panorama Client ID:**
Phone number:	**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 ☐ 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		YYYY / MM / DD	Pain – abdominal		YYYY / MM / DD
Bleeding - vaginal – abnormal		YYYY / MM / DD	Pain – deep pelvic (dyspareunia)		YYYY / MM / DD
Cervicitis (strawberry/friable cervix, cervical discharge)		YYYY / MM / DD	Urethritis (urethra discharge, dysuria)		YYYY / MM / DD
Discharge - vaginal		YYYY / MM / DD	Other:		YYYY / MM / DD
Epididymitis (*Gonococcal infection only*)		YYYY / MM / DD			

F) TREATMENT

Date treated: YYYY / MM / DD **Treated By:** **Direct Observed Therapy (DOT)** ☐ Yes ☐ No

☐ Azithromycin 1gm ☐ 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.					

Confidential Notification of Sexual Contacts
Of persons diagnosed with Chlamydia or Gonococcal Infections

(*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

Exposure Type: ☐ Vaginal ☐ Oral ☐ Anal ☐ Delivery/Perinatal

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

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

Exposure Type: ☐ Vaginal ☐ Oral ☐ Anal ☐ Delivery/Perinatal

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

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: