BC Centre for Disease Control
An agency of the Provincial Health Services Authority

CONFIDENTIAL NOTIFICATION OF SEXUALLY TRANSMITTED INFECTION

HLTH 208 Case Report Form

Clinical Prevention Services – Clinic Tel: (604) 707 - 5600

FAX this form to: Clinical Prevention Services – Clinic at 604 707 - 5604	**or**	**MAIL** this form in an envelope marked "CONFIDENTIAL" to: Clinical Prevention Services – Clinic 655 West 12th Avenue, Vancouver, BC V5Z 4R4

A. CLIENT INFORMATION

Name

Last *First* *Middle*

Alternate Name(s) | Date of Birth *YYYY/MM/DD* | PHN

What sex/gender does client identify with? (check all that apply)

☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Two-Spirit

☐ Unsure/Questioning ☐ My gender is: ______________________ ☐ Prefer not to answer

Which sex/gender is listed on the client's BC Services Card or CareCard? ○ Male ○ Female ○ X

Does client self-identify as an Indigenous person? ○ Yes (check all that apply) ○ No

☐ First Nations ☐ Inuit ☐ Métis ☐ Asked but not known ☐ Asked but not provided ☐ Did not ask

If client does not self-identify as an Indigenous person, which ethnicity/race does this client self-identify with? (check all that apply)
If client self-identifies as an Indigenous person, does client self-identify with any other ethnicity/race? (check all that apply)

☐ White ☐ Black ☐ Chinese ☐ South Asian ☐ Southeast Asian

☐ West Asian or Arab ☐ Korean ☐ Japanese ☐ Filipino ☐ Latin American

☐ Other race ☐ Unknown ☐ Declined to answer

Home Address | City | Postal Code | Province

Phone Number (home) | Phone Number (cell) | Email

Reason for testing	Is the client currently pregnant?	Gender of sexual partners (check all that apply)	Is the client on HIV PrEP?
☐ Routine screening	○ Yes _______ weeks *or* EDD _______	☐ Male	○ Yes
☐ Symptomatic	○ No	☐ Female	○ No
☐ Sexual partner diagnosed with STI	○ Unknown	☐ Transgender	○ Unknown
☐ Other ______________________		☐ Unknown	

B. INFECTION and TREATMENT

CHLAMYDIA TRACHOMATIS (lab confirmed)

Specimen collection date *YYYY/MM/DD*

Specify diagnosis site / specimen (check all that apply)

☐ Urethra ☐ Urine ☐ Vagina ☐ Cervix

☐ Rectum ☐ Throat ☐ Other site ______________

Treatment

☐ Doxycycline 100 mg PO bid for 7 days

☐ Azithromycin 1 g PO in a single dose

☐ Other ______________________________

☐ Not treated for Chlamydia

Date treatment initiated *YYYY/MM/DD*

GONORRHEA (lab confirmed)

Specimen collection date *YYYY/MM/DD*

Specify diagnosis site / specimen (check all that apply)

☐ Urethra ☐ Urine ☐ Vagina ☐ Cervix

☐ Rectum ☐ Throat ☐ Other site ______________

Treatment

☐ Cefixime 800 mg PO in a single dose plus Azithromycin 1 g PO in a single dose

☐ Ceftriaxone 250 mg IM in a single dose plus Azithromycin 1 g PO in a single dose

☐ Other ______________________________

☐ Not treated for Gonorrhea

Date treatment initiated *YYYY/MM/DD*

C. PARTNER NOTIFICATION

Who will notify this client's sexual partner(s) to get tested and treated?

☐ I (testing provider or clinic) will notify the partner(s)

☐ Client will notify the partner(s)

☐ Please have public health contact client to discuss partner notification

☐ Other, specify ______________________________

D. TESTING PROVIDER / AGENCY

Testing Provider Name (please print) | Clinic or Agency Name | Testing / Clinic provider billing (MSP) number

Address | Phone | Fax

City | Postal Code | Date form completed *YYYY/MM/DD*