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:	**or**	**MAIL** this form in an envelope marked "CONFIDENTIAL" to:

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

Does client self-identify as an Aboriginal Person, that is, First Nations, Inuit or Métis? ☐ 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 Aboriginal Person, which ethnicity/race does this client self-identify with?
If client self-identifies as an Aboriginal Person, does client self-identify with any other additional ethnicity/race?

☐ White ☐ Black ☐ Chinese ☐ South Asian ☐ Southeast Asian
☐ West Asian or Arab ☐ Korean ☐ Japanese ☐ Filipino ☐ Latin American
☐ Other/Mixed race ☐ Unknown ☐ Declined to answer

Home Address	City	Postal Code	Province

Phone Number (home/office/cell)	Phone Number (home/office/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 ☐ Symptomatic ☐ Sexual partner diagnosed with STI ☐ Other _____	☐ Yes _____ weeks *or* EDC _____ ☐ No ☐ Unknown	☐ Male ☐ Female ☐ Transgender	☐ Yes ☐ No ☐ 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*	