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 ○ 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 ☐ Symptomatic ☐ Sexual partner diagnosed with STI ☐ Other _____	○ Yes _____ weeks *or* EDD _____ ○ No ○ Unknown	☐ Male ☐ Female ☐ Transgender ☐ Unknown	○ 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*	