



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 12 th Avenue, Vancouver, BC V5Z 4R4
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A. CLIENT INFORMATION

Name					
<i>Last</i>	<i>First</i>	<i>Middle</i>			
Alternate Name(s)	Date of Birth	PHN			
YYYY/MM/DD					
What sex/gender does client identify with? (check all that apply)					
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-binary		
<input type="checkbox"/> Unsure/Questioning	<input type="checkbox"/> My gender is: _____		<input type="checkbox"/> Two-Spirit		
<input type="checkbox"/> Prefer not to answer					
Which sex/gender is listed on the client’s BC Services Card or CareCard?					
<input type="checkbox"/> Male		<input type="checkbox"/> Female			
Does client self-identify as an Aboriginal Person, that is, First Nations, Inuit or Métis?					
<input type="checkbox"/> Yes (check all that apply)		<input type="checkbox"/> No			
<input type="checkbox"/> First Nations	<input type="checkbox"/> Inuit	<input type="checkbox"/> Métis	<input type="checkbox"/> Asked but not known		
<input type="checkbox"/> Asked but not provided	<input type="checkbox"/> 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?					
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Chinese	<input type="checkbox"/> South Asian		
<input type="checkbox"/> Southeast Asian	<input type="checkbox"/> West Asian or Arab	<input type="checkbox"/> Korean	<input type="checkbox"/> Japanese		
<input type="checkbox"/> Filipino	<input type="checkbox"/> Latin American	<input type="checkbox"/> Other/Mixed race			
<input type="checkbox"/> Unknown		<input type="checkbox"/> 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)		
<input type="checkbox"/> Routine screening	<input type="checkbox"/> Yes _____ weeks or EDC _____	<input type="checkbox"/> No	<input type="checkbox"/> Male		
<input type="checkbox"/> Symptomatic				<input type="checkbox"/> Female	
<input type="checkbox"/> Sexual partner diagnosed with STI					<input type="checkbox"/> Transgender
<input type="checkbox"/> Other _____					
		<input type="checkbox"/> Unknown	Is the client on HIV PrEP?		
			<input type="checkbox"/> Yes		
			<input type="checkbox"/> No		
			<input type="checkbox"/> Unknown		

B. INFECTION and TREATMENT

CHLAMYDIA TRACHOMATIS (lab confirmed) Specimen collection date YYYY/MM/DD Specify diagnosis site / specimen (check all that apply) <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Vagina <input type="checkbox"/> Cervix <input type="checkbox"/> Rectum <input type="checkbox"/> Throat <input type="checkbox"/> Other site _____ Treatment <input type="checkbox"/> Doxycycline 100 mg PO bid for 7 days <input type="checkbox"/> Azithromycin 1 g PO in a single dose <input type="checkbox"/> Other _____ <input type="checkbox"/> 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) <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Vagina <input type="checkbox"/> Cervix <input type="checkbox"/> Rectum <input type="checkbox"/> Throat <input type="checkbox"/> Other site _____ Treatment <input type="checkbox"/> Ceftriaxone 500mg IM in a single dose (preferred) <input type="checkbox"/> Cefixime 800mg PO in a single dose plus Doxycycline 100mg PO BID x 7 days <input type="checkbox"/> Cefixime 800mg PO in a single dose plus Azithromycin 1 g PO in a single dose <input type="checkbox"/> Not treated for Gonorrhea Date treatment initiated YYYY/MM/DD
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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)

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