MHSU 6781 - PROVIDER REPORT FORM FOR SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS (STBBI) AND STI TREATMENT

Health, Seniors and Long-Term Care

NEW REPORT ___________________ (YYYY-MM-DD) UPDATED REPORT ___________________ (YYYY-MM-DD)

I. CLIENT IDENTIFICATION

subject>client details>personal information

LAST NAME	FIRST NAME	DATE OF BIRTH (YYYY-MM-DD)
SEX FEMALE INTERSEX MALE UNKNOWN	**GENDER IDENTITY (VOLUNTARY, SELF-REPORTED)** CISGENDER (SAME AS SEX AT BIRTH) TRANSGENDER PERSON DECLINED TRANSGENDER MAN TRANSGENDER WOMAN OTHER (SPECIFY)	**AGE (YRS)** (IF DOB NOT COMPLETED)
REGISTRATION NUMBER (FORMER MHSC) 6 DIGITS | UPPERCASE ALPHANUMERIC	**HEALTH NUMBER (PHIN)** 9 DIGITS	**ALTERNATE ID** SPECIFY TYPE OF ID
ADDRESS AT TIME OF DIAGNOSIS ➔ **ADDRESS IN FIRST NATION COMMUNITY**		**CITY/TOWN/VILLAGE**
PROVINCE/TERRITORY	**POSTAL CODE (A# A# A#)**	**PHONE NUMBER (### - ### - ####)**
ALTERNATE IDENTIFYING OR LOCATION INFORMATION (IF ANY. E.G. ALTERNATE NAME, SOCIAL MEDIA, ALTERNATE ADDRESS)		
PREVIOUS NON-NOMINAL CODE(S) OR NAME(S) USED FOR POSITIVE HIV TESTS IF APPLICABLE (SPECIFY COUNTRY/PROVINCE, CODE/NAME, AND DATES YYYY-MM-DD IF KNOWN)		

II. PREGNANCY

subject > risk factors

IS CLIENT PREGNANT/POST PARTUM?	YES	EDD OR DELIVERY DATE:	(YYYY-MM-DD)	NO	UNKNOWN

III. INFECTION INFORMATION

investigation > investigation details > disease summary > update > disease event history

REASON FOR REPORTING:	LAB CONFIRMED INFECTION(S) (SPECIFY BELOW)	STBBI TREATMENT PROVIDED (CONTACTS OR CLINICAL CASES) (TEST RESULTS PENDING OR NOT DONE) PROCEED TO TREATMENT INFORMATION

LAB CONFIRMED INFECTIONS (CHECK ALL THAT APPLY)	CHLAMYDIA GONORRHEA	CHANCROID	LGV	HEPATITIS B	HEPATITIS C	HIV	SYPHILIS
SPECIMEN COLLECTION DATE (YYYY–MM–DD)							

IV. TREATMENT INFORMATION

investigation > prescriptions > prescription summary

PRESCRIBER NAME		PRESCRIBER/TREATMENT FACILITY		
SYPHILIS	BENZATHINE PENICILLIN G 2.4 million units, IM, 1 dose START DATE (YYYY-MM-DD):	BENZATHINE PENICILLIN G 2.4 million units, IM weekly, 2 doses START DATE (YYYY-MM-DD):	BENZATHINE PENICILLIN G 2.4 million units, IM weekly, 3 doses START DATE (YYYY-MM-DD):	CEFTRIAXONE 1 g daily x 10 days, IV / IM (circle one) START DATE (YYYY-MM-DD):
	CEFTRIAXONE 2 g daily x 10 days, IV / IM (circle one) START DATE (YYYY-MM-DD):	DOXYCYCLINE 100 mg PO BID x 14 days START DATE (YYYY-MM-DD):	DOXYCYCLINE 100 mg PO BID x 28 days START DATE (YYYY-MM-DD):	PENICILLIN G 3 - 4 M IV Q4H x 10-14 days START DATE (YYYY-MM-DD):
CHLAMYDIA, GONORRHEA	AZITHROMYCIN 1g PO, single dose START DATE (YYYY-MM-DD):	CEFIXIME 800 mg PO, single dose START DATE (YYYY-MM-DD):	DOXYCYCLINE 100 mg PO BID x 7 days START DATE (YYYY-MM-DD):	METRONIDAZOLE 500 mg PO BID x 14 days START DATE (YYYY-MM-DD):
	AMOXICILLIN 500 mg PO TID x 7 days START DATE (YYYY-MM-DD):	CEFTRIAXONE 250 mg IM, single dose START DATE (YYYY-MM-DD):	ERYTHROMYCIN 500 mg PO QID x 7 days START DATE (YYYY-MM-DD):	
OTHER TREATMENT (LGV | OTHER INFECTION, IF APPLICABLE)	SPECIFY:			START DATE (YYYY-MM-DD):
UPDATE TO PREVIOUS INFORMATION SUBMITTED	SPECIFY DETAILS ON ANY CHANGE TO SYPHILIS TREATMENT PLAN (E.G. CLIENT DID NOT ATTEND FOR ANOTHER DOSE)			
	PREVIOUSLY REPORTED TREATMENT PRIOR TO POSITIVE TEST – PROVIDE FORM COMPLETION DATE (YYYY-MM-DD)			

CLIENT LAST NAME:	CLIENT FIRST NAME:
PHIN:	DOB: (YYYY-MM-DD)

V. PRESENTATION/STAGING (FOR LAB CONFIRMED CASES ONLY)

investigation > investigation details > investigation information

COMPLETE FOR CHLAMYDIA, GONORRHEA, LGV, CHANCROID ONLY

PRESENTATION

ARTHRITIS | GENITAL | PHARYNGEAL | RECTAL/ANAL | OTHER (SPECIFY):
EYE | PELVIC INFLAMMATORY DISEASE | PNEUMONIA

COMPLETE FOR HEPATITIS B, HEPATITIS C, AND HIV ONLY

HEPATITIS B STAGING	HEPATITIS C STAGING	HIV STAGING
ACUTE	ACUTE (INCLUDES RE-INFECTIONS)	NEW DIAGNOSIS
CHRONIC	CHRONIC (INCLUDES RE-INFECTIONS)	PERINATAL CASE
PERINATAL CASE	PERINATAL CASE	PREVIOUS DIAGNOSIS- NEW TO MANITOBA
PREVIOUS DIAGNOSIS- CHRONIC	RESOLVED	OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MANITOBA
UNKNOWN/UNDETERMINED	PREVIOUS DIAGNOSIS- CHRONIC	UNKNOWN/UNDETERMINED
	PREVIOUS DIAGNOSIS	
	UNKNOWN/UNDETERMINED	

COMPLETE FOR SYPHILIS ONLY

SYPHILIS SIGNS/SYMPTOMS (CHECK ALL THAT APPLY)

SYMPTOM ONSET DATE
START DATE (YYYY-MM-DD):

ASYMPTOMATIC | ANAL ULCERATIVE LESIONS | CONDYLOMATA LATA
GENITAL ULCER | HAIR LOSS (ALOPECIA) | MENINGITIS
OCULAR INVOLVEMENT | ORAL ULCERATIVE LESIONS | RASH
OTHER (SPECIFY):

SYPHILIS STAGING

PRIMARY | SECONDARY | EARLY LATENT (LESS THAN 1 YEAR AFTER INFECTION)
LATE LATENT (GREATER THAN 1 YEAR AFTER INFECTION) | TERTIARY
UNKNOWN/UNDETERMINED | PREVIOUS DIAGNOSIS*

ADDITIONAL PRESENTATIONS (SITES) NEUROSYPHILIS | GUMMATOUS SYPHILIS | CARDIOVASCULAR SYPHILIS

*(IF RECORD OF TREATMENT OUTSIDE MANITOBA PLEASE PROVIDE IN SECTION VII - ADDITIONAL INFORMATION)

VI. RISK FACTOR INFORMATION (OPTIONAL)

subject > risk factors

SPECIFY KNOWN APPLICABLE RISK FACTORS IF RELEVANT TO THE PUBLIC HEALTH INVESTIGATION:

HOUSING UNSTABLE
INJECTION DRUG USE
HISTORY OF INCARCERATION
MEN WHO HAVE SEX WITH MEN
PROBABLE ACQUISITION IN ANOTHER COUNTRY
OTHER (DESCRIBE OTHER RELEVANT RISK FACTORS OR ADDITIONAL INFORMATION ON ABOVE RISK FACTORS)

ADDITIONAL INFORMATION:

VII. ADDITIONAL INFORMATION (IF APPLICABLE)

ADDITIONAL UPDATES TO PREVIOUS INFORMATION SUBMITTED

FOR LABORATORY CONFIRMED CASES ONLY

HAS CLIENT/GUARDIAN BEEN INFORMED OF DIAGNOSIS? YES NO PENDING

(HIV CASE ONLY) HAS NEED FOR HIV DISCLOSURE WITH PARTNERS BEEN DISCUSSED WITH CLIENT/GUARDIAN? YES NO

(HIV CASE ONLY) HAS CLIENT BEEN REFERRED TO MANITOBA HIV PROGRAM YES NO PENDING

VIII. REPORTER INFORMATION

FORM COMPLETED BY (PRINT NAME)	FACILITY NAME/ ADDRESS/ PHONE #
FORM COMPLETION DATE (YYYY-MM-DD)	

REMINDER: TESTING FOR ALL STBBI IS RECOMMENDED

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CLIENT LAST NAME:	CLIENT FIRST NAME:
PHIN:	DOB: (YYYY-MM-DD)

IX. CONTACTS OF CASE (FOR LAB CONFIRMED CASES ONLY)

COPY PAGE IF REQUIRED. PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE.

investigation quick entry > exposure summary > create transmission event > known contacts contact investigation > disposition / intervention

CASE DECLINED TO IDENTIFY CONTACTS

NUMBER OF ANONYMOUS CONTACTS ___________________

CONTACT PERSONAL INFORMATION	PREGNANT?	WHO WILL NOTIFY?	EXPOSURE START AND END DATES YYYY-MM-DD
NAME: PHIN (IF KNOWN): DOB/AGE: ADDRESS: PHONE: ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):	YES NO UNKNOWN N/A	PUBLIC HEALTH CASE HEALTH CARE PROVIDER	START DATE END DATE
NAME: PHIN (IF KNOWN): DOB/AGE: ADDRESS: PHONE: ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):	YES NO UNKNOWN N/A	PUBLIC HEALTH CASE HEALTH CARE PROVIDER	START DATE END DATE
NAME: PHIN (IF KNOWN): DOB/AGE: ADDRESS: PHONE: ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):	YES NO UNKNOWN N/A	PUBLIC HEALTH CASE HEALTH CARE PROVIDER	START DATE END DATE
NAME: PHIN (IF KNOWN): DOB/AGE: ADDRESS: PHONE: ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):	YES NO UNKNOWN N/A	PUBLIC HEALTH CASE HEALTH CARE PROVIDER	START DATE END DATE

PLEASE SUBMIT THIS FORM: MHSU-6781 (2024-09) – PROVIDER REPORT FORM FOR SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS (STBBI) AND STI TREATMENT, BY SECURED FAX OR COURIER TO THE MANITOBA HEALTH SURVEILLANCE UNIT. 4050 – 300 CARLTON ST. WINNIPEG, MB | CONFIDENTIAL FAX 204-948-3044 AFTER HOURS EMERGENCY PHONE FOR PUBLIC HEALTH ISSUES IS (204) 788-8666.

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