

CASE ACCESSION NUMBER

ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)



STI CASE INVESTIGATION FORM FOR CHLAMYDIA, GONORRHEA, CHANCROID AND LGV INFECTIONS **CASE FORM**

I. *CASE IDENTIFICATION

subject > client details > personal information

1. *LAST NAME		2. *FIRST NAME		3. *DATE OF BIRTH YYYY - MM - DD	
4. ALTERNATE LAST NAME			5. ALTERNATE FIRST NAME		
6. *SEX <input type="radio"/> FEMALE <input type="radio"/> MALE <input type="radio"/> INTERSEX <input type="radio"/> UNKNOWN		7. *GENDER IDENTITY (VOLUNTARY, SELF-REPORTED) <input type="radio"/> CISGENDER (SAME AS SEX AT BIRTH) <input type="radio"/> TRANSGENDER MAN <input type="radio"/> TRANSGENDER WOMAN <input type="radio"/> TRANSGENDER PERSON <input type="radio"/> DECLINED <input type="radio"/> OTHER (SPECIFY IN BOX 8)		8. IF OTHER GENDER IDENTITY, SPECIFY	
9. *REGISTRATION NUMBER (FORMER MHSC) 6 DIGITS UPPERCASE ALPHANUMERIC		10. *HEALTH NUMBER (PHIN) 9 DIGITS		11. ALTERNATE ID SPECIFY TYPE OF ID	
12. *ADDRESS AT TIME OF DIAGNOSIS → <input type="checkbox"/> ADDRESS IN FIRST NATION COMMUNITY				13. *CITY/TOWN/VILLAGE	
14. *PROVINCE/TERRITORY		15. *POSTAL CODE A#A #A#		16. *PHONE NUMBER ### - ### - ####	
17. *RACIAL/ETHNIC IDENTITY (VOLUNTARY, SELF-REPORTED) <input type="radio"/> AFRICAN <input type="radio"/> BLACK <input type="radio"/> CHINESE <input type="radio"/> DECLINED <input type="radio"/> FILIPINO <input type="radio"/> LATIN AMERICAN <input type="radio"/> NORTH AMERICAN INDIGENOUS <input type="radio"/> OTHER (SPECIFY): <input type="radio"/> SOUTH ASIAN <input type="radio"/> SOUTHEAST ASIAN <input type="radio"/> WHITE					
18. *INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, SELF-REPORTED) <input type="radio"/> FIRST NATIONS <input type="radio"/> MÉTIS <input type="radio"/> INUIT <input type="radio"/> NOT ASKED <input type="radio"/> DECLINED		19. *FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED) <input type="radio"/> STATUS <input type="radio"/> NON-STATUS <input type="radio"/> NOT ASKED <input type="radio"/> DECLINED		MHSU USE ONLY	
20. ALTERNATE LOCATION INFORMATION (IF ANY)					

II. INVESTIGATION INFORMATION

investigation > investigation details > disease summary > disease event

21. *INVESTIGATION DISPOSITION		<input type="radio"/> FOLLOW-UP COMPLETE <input type="radio"/> FOLLOW-UP COMPLETE BY OTHER PROVIDER, NO PH FOLLOW-UP <input type="radio"/> UNABLE TO LOCATE	
22. *PRIMARY INVESTIGATOR ORGANIZATION		<input type="radio"/> WRHA <input type="radio"/> NRHA <input type="radio"/> PMH <input type="radio"/> SH-SS <input type="radio"/> IERHA <input type="radio"/> FNIHB <input type="radio"/> CSC	
23. OTHER ORGANIZATIONS INVOLVED		<input type="checkbox"/> WRHA <input type="checkbox"/> NRHA <input type="checkbox"/> PMH <input type="checkbox"/> SH-SS <input type="checkbox"/> IERHA <input type="checkbox"/> FNIHB <input type="checkbox"/> CSC <input type="checkbox"/> DND	

III. *INFECTION INFORMATION

investigation > subject summary > STBBI encounter group

24. *CASE CLASSIFICATION							
<input type="checkbox"/> CHLAMYDIA		<input type="checkbox"/> GONORRHEA		<input type="checkbox"/> LGV		<input type="checkbox"/> CHANCROID	
YYYY-MM-DD		YYYY-MM-DD		YYYY-MM-DD		YYYY-MM-DD	
SPECIFY SPECIMEN COLLECTION DATE →		SPECIFY SPECIMEN COLLECTION DATE →		SPECIFY SPECIMEN COLLECTION DATE →		SPECIFY SPECIMEN COLLECTION DATE →	
25. *PRESENTATION (SITES)							
investigation > investigation details > disease summary > update > disease event history							
<input type="checkbox"/> GENITAL	<input type="checkbox"/> PHARYNGEAL	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> OTHER MALE GENITAL ORGANS	<input type="checkbox"/> PELVIC INFLAMMATORY DISEASE	26. <input type="checkbox"/> OTHER		SPECIFY
<input type="checkbox"/> RECTAL	<input type="checkbox"/> EYE	<input type="checkbox"/> LYMPH NODES	<input type="checkbox"/> PNEUMONIA				

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

CSSE ACCESSION NUMBER

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IV. SIGNS AND SYMPTOMS

investigation > signs and symptoms

27. SIGNS AND SYMPTOMS <input type="radio"/> ASYMPTOMATIC <input type="radio"/> SYMPTOMATIC	28. EARLIEST SYMPTOMS ONSET DATE YYYY-MM-DD
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V. RISK FACTOR INFORMATION

subject > risk factors

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED: REQUIRED RISK FACTORS INDICATED WITH * MUST HAVE A RESPONSE DOCUMENTED IN PHIMS	YES	NO	UNKNOWN	DECLINED TO ANSWER	NOT ASKED
*PREGNANT AT TIME OF DIAGNOSIS SPECIFY EDC YYYY-MM-DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BORN TO INFECTED MOTHER/ BIRTH PARENT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HOUSING UNSTABLE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MSM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEXUAL PARTNER AT RISK	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CONTACT TO NEW OR PREVIOUSLY DIAGNOSED CASE SPECIFY INFECTION AND DATE YYYY-MM-DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER RISK FACTOR (FOR LGV OR CHANCROID REFER TO PROTOCOL) SPECIFY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

VI. EVIDENCE-BASED RECOMMENDED INTERVENTIONS

treatment & interventions > interventions summary

<input type="checkbox"/> PREVENTION EDUCATION/COUNSELLING AS PER DISEASE PROTOCOL	<input type="checkbox"/> REFERRAL FOR TREATMENT:(SPECIFY-INCLUDING REFERRAL FOR HIV PREP OR PEP
<input type="checkbox"/> IMMUNIZATION RECOMMENDED <input type="radio"/> HBV <input type="radio"/> HAV <input type="radio"/> HPV <input type="radio"/> MPOX	<input type="checkbox"/> STBBI TESTING RECOMMENDED <input type="radio"/> CT/GC <input type="radio"/> SYPHILIS <input type="radio"/> HBV <input type="radio"/> HCV <input type="radio"/> HIV
<input type="checkbox"/> AWAITING MEDICAL INFORMATION OR HISTORY	<input type="checkbox"/> TEST OF CURE RECOMMENDED
<input type="checkbox"/> TREATMENT RECOMMENDED	

For Gonorrhea and Chlamydia: If treatment is already documented in a provider form investigation it does not need to be re-entered into the disease investigation

VII. TREATMENT INFORMATION

investigation > medications > medication summary

29. PRESCRIBER NAME	30. TREATMENT FACILITY	31. <input type="checkbox"/> PROBABLE PREVIOUS TREATMENT FAILURE
<input type="checkbox"/> AZITHROMYCIN 1g PO X1 SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> DOXYCYLINE 100 mg PO BID X 7 DAYS SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> METRONIDAZOLE 500 mg PO BID X 14 DAYS SPECIFY START DATE: YYYY-MM-DD
<input type="checkbox"/> CEFIXIME 800 mg PO x1 SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> AMOXICILLIN 500 mg PO TID X 7 DAYS SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> OTHER (SPECIFY TREATMENT)
<input type="checkbox"/> CEFTRIAZONE 250 mg IM x1 SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> ERYTHROMYCIN 500 mg PO QID X 7 DAYS SPECIFY START DATE: YYYY-MM-DD	SPECIFY START DATE: YYYY-MM-DD
33. ALLERGIES (RELEVANT TO TREATMENT, IF ANY) SPECIFY		subject > allergies

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