

CHLAMYDIA TRACHOMATIS (CT)

HEALTHCARE PROVIDER INVESTIGATION & REPORTING FORM

The Health Protection and Promotion Act 1990 (HPPA), R.S.O., 1990, and Ontario Reg. 135/18, outlines the requirements for physicians, practitioners, and institutions to report any **disease of public health significance** to the Medical Officer of Health.

Completion of both pages of this form is required. The form is to be faxed by the next working day from the initial patient visit, to the Windsor-Essex County Health Unit (WECHU) – Infectious Disease Prevention Department (fax: 226-783-2132). **Refer to the *Canadian Guidelines on Sexually Transmitted Infections (STIs)* for diagnosis and management of STIs.**

DATE REPORTED (YY/MM/DD)	REPORTING PROVIDER NAME	PHONE NUMBER () - ext.
SECTION A: PATIENT INFORMATION		
PATIENT NAME (FIRST) (MIDDLE) (LAST)	SEX	DATE OF BIRTH (YY/MM/DD) AGE
ADDRESS (STREET) (CITY) (POSTAL CODE)		
HOME PHONE: () -	ALTERNATE PHONE: () -	

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client been notified of the laboratory result, indicating infection?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the client pregnant? If yes, indicate gestational age: _____ weeks

SECTION B: PRESENTING SYMPTOMS			
<input checked="" type="checkbox"/> FEMALES	Onset Date (YY/MM/DD)	<input checked="" type="checkbox"/> MALES	Onset Date (YY/MM/DD)
<input type="checkbox"/> Asymptomatic (most common)		<input type="checkbox"/> Asymptomatic (most common)	
<input type="checkbox"/> Lower abdominal pain		<input type="checkbox"/> Conjunctivitis	
<input type="checkbox"/> Cervicitis		<input type="checkbox"/> Dysuria	
<input type="checkbox"/> Conjunctivitis		<input type="checkbox"/> Testicular pain	
<input type="checkbox"/> Dyspareunia		<input type="checkbox"/> Urethral discharge	
<input type="checkbox"/> Dysuria		<input type="checkbox"/> Urethral itch	
<input type="checkbox"/> Vaginal discharge		<input type="checkbox"/> Urethritis	
<input type="checkbox"/> Other, specify:		<input type="checkbox"/> Other, specify:	

SECTION C: RISKS FOR INFECTION AND COMPLICATIONS	
<input checked="" type="checkbox"/> RISK FACTORS	
<input type="checkbox"/> Sexual contact of a confirmed chlamydia case	<input type="checkbox"/> No condom use
<input type="checkbox"/> Those with street involvement/homeless	<input type="checkbox"/> Condom breakage
<input type="checkbox"/> Anonymous sex partners	<input type="checkbox"/> Alcohol and/or drug use
<input type="checkbox"/> Multiple sex partners	<input type="checkbox"/> Sex trade worker
<input type="checkbox"/> New sexual contact in the past 2 months	<input type="checkbox"/> Sex with same sex
<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Other, specify: _____



SECTION D: INFECTION MANAGEMENT							
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Was treatment provided to the client? If yes, specify medication & date below.</p> <p>If patients have a positive test, are symptomatic, or have a known positive contact, treatment is warranted. Empirical co-treatment is indicated when diagnosed with gonorrhea without waiting for test results of CT due to high probability of co-infection.</p> <p>NOTE: Free STIs medications can be ordered from the WECHU to have in your office for prompt treatment.</p> <p>TREATMENT PER GUIDELINES FOR NON-PREGNANT AND NON-LACTATING ADULTS (refer to the Canadian Guidelines on STIs for all other cases)</p> <table border="1"> <tr> <td><input type="checkbox"/> Azithromycin 1 g PO single dose OR</td> <td>DATE GIVEN (YY/MM/DD):</td> </tr> <tr> <td><input type="checkbox"/> Doxycycline 100 mg PO bid for 7 days</td> <td>DATE GIVEN (YY/MM/DD):</td> </tr> <tr> <td><input type="checkbox"/> Other, specify:</td> <td>DATE GIVEN (YY/MM/DD):</td> </tr> </table>	<input type="checkbox"/> Azithromycin 1 g PO single dose OR	DATE GIVEN (YY/MM/DD):	<input type="checkbox"/> Doxycycline 100 mg PO bid for 7 days	DATE GIVEN (YY/MM/DD):	<input type="checkbox"/> Other, specify:	DATE GIVEN (YY/MM/DD):
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<input type="checkbox"/> Other, specify:	DATE GIVEN (YY/MM/DD):						
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Advise client to inform sexual partners to see a health care provider for testing and treatment. Inform client that WECHU can assist with anonymous partner notification.</p>						
#: _____	# of sexual partners identified by the client 60 days prior.						

SECTION E: CLIENT EDUCATION	
<input type="checkbox"/>	Counsel client regarding transmission and prevention methods. Advise client/contacts to abstain from or have protected intercourse of all types (anal, oral, and vaginal) until treatment of both partners is complete (i.e. after completion of multiple-dose treatment or for 7 days after single-dose therapy).
<input type="checkbox"/>	<p>Inform client to return for a test of cure if: symptoms or signs persist post-therapy; treatment compliance is suboptimal; the preferred treatment regimen was not used; the person is prepubertal; or the person is pregnant.</p> <p>When a test of cure is recommended, NAAT should be performed 3-4 weeks after completion of treatment.</p> <p>A test of cure is not routinely indicated if recommended treatment is taken AND symptoms and signs disappear AND there is no re-exposure to an untreated partner.</p>
<input type="checkbox"/>	Inform client that repeat testing for CT is recommended 3 months post-treatment, because the risk of reinfection is high.
<input type="checkbox"/>	Inform client that a nurse from the WECHU may be contacting them.

* The **Public Health Lab Service Desk (1-877-604-4567)** is available to answer questions regarding specimen collection. An online test information index is also available at www.publichealthontario.ca.

REPORTING HEALTHCARE PROVIDER’S SIGNATURE: _____

The most current form is available on our website:
<https://www.wechu.org/forms/>

For more information: 519-258-2146 ext. 1420
 Infectious Disease Prevention
www.wechu.org
 MARCH 2022/COMMUNITY/CHLAMYDIA