Report of ☐Chlamydia or ☐Gonorrhea - **Please use this form for reporting LAB CONFIRMED chlamydia and/or gonorrhea. Fax completed form to 905-940-4541**

Health Care Provider information: **(Name, Address, Phone, Fax)**	
Client information: **(Name, Sex, DOB, Phone, Address, Language)**	

➡ **PLEASE INDICATE**

☐ Yes ☐ No – CLIENT HAS BEEN INFORMED OF THEIR STI(s) AND RECEIVED HEALTH TEACHING

York Region Public Health recommends that your health teaching include:

- Transmission of Sexually Transmitted Infections (STIs) and reinforce measures for protection from future STIs including safer sex practices and condom use
- Advising your client to abstain from having sexual activity for 7 days following the treatment of all those involved
- Follow up for STI retesting discuss further STI screening including HIV and the HIV window period
- Discussion on partner notification, notifying all partners within 60 days prior to diagnosis of any partners at risk

➡ **PLEASE INDICATE**

TREATMENT:

CHLAMYDIA TREATMENT		TREATMENT DATE yy/mm/dd
☐ **Azithromycin 1g single dose PO**	***FIRST LINE TREATMENT***	
☐ **Doxycycline 100 mg BID x 7 days PO**	***FIRST LINE TREATMENT***	
☐ Other:		

GONORRHEA TREATMENT	TREATMENT DATE yy/mm/dd
☐ **Ceftriaxone 250 mg IM + Azithromycin 1g PO** ***FIRST LINE TREATMENT***	
☐ Cefixime 400mg PO + Azithromycin 1g single dose PO	
☐ Other:	

POSITIVE TEST SITES

☐ URINE   ☐ URETHRAL   ☐ VAGINAL/CERVICAL   ☐ RECTAL   ☐ PHARYNGEAL   ☐ OTHER:_____

TEST OF CURE (TOC) - *PLEASE ADVISE CLIENT AS APPLICABLE*:

Chlamydia: If using Nucleic Acid Amplification Test (NAAT), perform ≥ 1 month post treatment to reduce false positive results.
Gonorrhea: Culture preferred for Gonorrhea TOC perform ≥ 3-7 days post treatment or if using NAAT for TOC ≥ 2-3 weeks.

☐ **CLIENT ADVISED TO HAVE A TEST OF CURE, PLANNED DATE (yy/mm/dd):** _____

TOC is recommended for the following:
a) prenatal   b) did NOT receive first line treatment   c) post therapeutic abortion   d) pharyngeal gonorrhea   e) gonorrheal PID or dissemination   f) children under 12 years of age

➡ **RESPONSIBILITY FOR NOTIFICATION FOR ALL CONTACTS - # OF CONTACTS ____**

☐ Client - Client has taken responsibility to inform contacts(s)

☐ Health Care Provider - Health care provider will provide each contact with STI information regarding prevention, testing, and treatment

☐ Public Health - Client has requested anonymous notification of contact(s). Please provide any known identifying information about each contact(s) including name, gender, address, telephone number, age/date of birth.

☐ Unable to Follow - Client does not have sufficient information to contact contact(s)

☐ Not discussed with client

4261 Highway 7 East, Suites B6 – 9, Unionville, ON L3R 9W6
1-877-464-9675 • TTY 1-866-512-6228 • Fax 905-940-4541
www.york.ca/sexualhealth

York Region

REASONS FOR TESTING:
☐ ROUTINE SCREENING   ☐ SYMPTOMS   ☐ CONTACT TRACING ☐ IMMIGRATION SCREENING   ☐ PrEP WORK-UP
☐ SEXUAL ASSAULT   ☐ THERAPEUTIC ABORTION   ☐ PRENATAL –EDD :_____   ☐ OTHER:_____

SYMPTOMS: **START DATE:_____**   **END DATE (yy/mm/dd):_____**
☐ ASYMPTOMATIC
☐ DISCHARGE PURULENT   ☐ URINATION DIFFICULTY   ☐ URINARY FREQUENCY   ☐ URETHRAL IRRITATION
☐ BLOOD IN URINE   ☐ ABNORMAL VAGINAL BLEEDING   ☐ RECTAL PAIN   ☐ PAINFUL INTERCOURSE
☐ SORE THROAT   ☐ OTHER: _____

ASSESSMENT OF RISK FACTORS

EXPOSURE SETTING	BEHAVIOURAL / SOCIAL FACTORS	
☐ BATH HOUSE	☐ ANONYMOUS SEX	
☐ CORRECTIONAL FACILITY	☐ NO CONDOM USED	☐ CONDOM BREAKAGE
☐ TRAVEL TO_____	☐ SEX WITH OPPOSITE SEX	☐ SEX WITH SAME SEX
☐ UNDERHOUSED / HOMELESS	☐ SEX WITH TRANS	☐ SHARED SEX TOYS
☐ UNKNOWN	☐ SEX WITH SEX TRADE WORKER ☐ SEX TRADE WORKER	
☐ OTHER:_____	☐ JUDGEMENT IMPAIRED BY ALCHOL / DRUGS	
MEDICAL RISK FACTORS	☐ NEW CONTACT IN PAST 2 MONTHS	
☐ CO-INFECTION WITH _____	☐ MORE THAN ONE SEX CONTACT IN LAST 6 MONTHS #_____	
☐ POSITIVE HIV STATUS	☐ MET CONTACT THROUGH INTERNET SITES_____	
☐ REPEAT STI	☐ CONTACT VISITING FROM OUTSIDE PROVINCE	
☐ PREGNANT	☐ SEX FOR DRUGS/SHELTER/FOOD/SURVIVAL	
☐ ON PrEP	☐ UNKNOWN	
☐ UNKNOWN	☐ OTHER:_____	
☐ OTHER:_____		

Is this patient currently on Pre-Exposure Prophylaxis (PrEP)? ☐ Yes ☐ No
***PrEP** is a highly effective HIV prevention medication regime. For more information or to learn how to prescribe PrEP in your clinical practice visit www.ontarioprep.ca.

Have other STI tests been done (indicate results)?
☐ Chlamydia_____   ☐ Gonorrhea_____   ☐ Hep B_____   ☐ Hep C_____   ☐ Syphilis
_____
☐ HIV_____   ☐ Other_____

To order free STI Medications: York Region Health Care Providers: To request a one-time STI treatment or to become a stock clinic provider, contact the Sexual Bloodborne On Duty Line at **1-877-464-9675 Ext. 74214** Outside York Region - Contact your local Health Unit

To order free hepatitis A and/or B vaccine for clients meeting eligibility criteria: For York Region Health Care Providers: please obtain an order form from http://bit.ly/YRvaccineorder and send completed vaccine order form via fax to **(905) 830-0578**, via email to **vaccineinventory@york.ca** or call **1-877-464-9675 Ext. 74033**. For Health Care Providers outside York Region: Contact your local Health Unit.

Comments:_____

Signature of Health Care Provider:_____   Date:_____

Chlamydia/Gonorrhea Case Report