* CASE ACCESSION NUMBER	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

Manitoba
Health, Seniors and Active Living

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	7. GENDER IDENTITY (VOLUNTARY, SELF-REPORTED)	8. IF OTHER GENDER IDENTITY, SPECIFY
◯ FEMALE ◯ MALE ◯ INTERSEX ◯ UNKNOWN	◯ CISGENDER (SAME AS SEX AT BIRTH) ◯ TRANSGENDER MAN ◯ TRANSGENDER WOMAN ◯ TRANSGENDER PERSON ◯ DECLINED ◯ OTHER (SPECIFY IN BOX 8)	

9. REGISTRATION NUMBER (FORMER MHSC)	10. HEALTH NUMBER (PHIN)	11. ALTERNATE ID
6 DIGITS	9 DIGITS	SPECIFY TYPE OF ID

12. ADDRESS AT TIME OF DIAGNOSIS ➔ ☐ ADDRESS IN FIRST NATION COMMUNITY	13. CITY/TOWN/VILLAGE

14. PROVINCE/TERRITORY	15. POSTAL CODE	16. PHONE NUMBER
	A#A #A#	### - ### - ####

15. RACIAL/ETHNIC IDENTITY (VOLUNTARY, SELF-REPORTED)

☐ AFRICAN ☐ BLACK ☐ CHINESE ☐ DECLINED
☐ FILIPINO ☐ LATIN AMERICAN ☐ NORTH AMERICAN INDIGENOUS ☐ OTHER (SPECIFY):
☐ SOUTH ASIAN ☐ SOUTHEAST ASIAN ☐ WHITE

18. INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, SELF-REPORTED)	19. FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED)	MHSU USE ONLY
◯ FIRST NATIONS ◯ MÉTIS ◯ INUIT ◯ NOT ASKED ◯ DECLINED	◯ STATUS ◯ NON-STATUS ◯ NOT ASKED ◯ DECLINED	

20. ALTERNATE LOCATION INFORMATION (IF ANY)

II. INVESTIGATION INFORMATION

21. *INVESTIGATION DISPOSITION	◯ FOLLOW-UP COMPLETE ◯ UNABLE TO COMPLETE INTERVIEW ◯ PENDING
22. *RESPONSIBLE ORGANIZATION	◯ WRHA ◯ NRHA ◯ PMH ◯ SH-SS ◯ IERHA ◯ FNIHB ◯ CSC
23. OTHER ORGANIZATIONS INVOLVED	☐ WRHA ☐ NRHA ☐ PMH ☐ SH-SS ☐ IERHA ☐ FNIHB ☐ CSC ☐ DND

III. *INFECTION INFORMATION

investigation > subject summary > STBBI encounter group

24. CASE CLASSIFICATION ◯ LAB CONFIRMED ◯ PROBABLE ◯ NOT A CASE

☐ CHLAMYDIA		☐ GONORRHEA		☐ LGV		☐ CHANCROID	
SPECIFY SPECIMEN COLLECTION DATE ➔	YYYY-MM-DD	SPECIFY SPECIMEN COLLECTION DATE ➔	YYYY-MM-DD	SPECIFY SPECIMEN COLLECTION DATE ➔	YYYY-MM-DD	SPECIFY SPECIMEN COLLECTION DATE ➔	YYYY-MM-DD

25. PRESENTATION (SITES)

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

☐ GENITAL ☐ PHARYNGEAL ☐ ARTHRITIS ☐ OTHER MALE GENITAL ORGANS ☐ PELVIC INFLAMMATORY DISEASE
☐ RECTAL ☐ EYE ☐ LYMPH NODES ☐ PNEUMONIA

26. ☐ OTHER SPECIFY

IV. SIGNS AND SYMPTOMS

investigation > signs and symptoms

27. SIGNS AND SYMPTOMS	28. EARLIEST SYMPTOMS ONSET DATE
◯ ASYMPTOMATIC ◯ SYMPTOMATIC	YYYY-MM-DD

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V. RISK FACTOR INFORMATION

subject > risk factors

A. EXPOSURE FACTORS

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
PREGNANT AT TIME OF DIAGNOSIS — SPECIFY EDC YYYY-MM-DD	○	○	○	○	○
CONTACT TO A NEW OR PREVIOUSLY DIAGNOSED CASE — SPECIFY INFECTION AND DATE YYYY-MM-DD	○	○	○	○	○
HAS GIVEN GOODS IN EXCHANGE FOR SEX	○	○	○	○	○
HAS RECEIVED GOODS IN EXCHANGE FOR SEX	○	○	○	○	○
HISTORY OF STI — SPECIFY INFECTION(S) AND DATE(S)	○	○	○	○	○
NEW SEX PARTNER WITHIN LAST 3 MONTHS	○	○	○	○	○
SEXUAL ASSAULT (NON-CONSENSUAL SEX)	○	○	○	○	○
SUBSTANCE USE - ALCOHOL USE DURING SEXUAL EXPOSURE	○	○	○	○	○
SUBSTANCE USE – OTHER THAN ALCOHOL DURING SEXUAL EXPOSURE — SPECIFY SUBSTANCE	○	○	○	○	○
TYPE OF SEXUAL EXPOSURE: ANAL	○	○	○	○	○
TYPE OF SEXUAL EXPOSURE: ORAL	○	○	○	○	○
TYPE OF SEXUAL EXPOSURE: VAGINAL	○	○	○	○	○
OTHER RISK FACTOR — SPECIFY	○	○	○	○	○

B. CONTACT SETTING LOCATION

subject > risk factors

29. **WHERE / HOW DID YOU FIRST MEET YOUR NEW SEXUAL PARTNER(S) OVER THE LAST 3 MONTHS?** (CHECK ALL THAT APPLY)

☐ BATHHOUSE — SPECIFY NAME AND LOCATION	☐ BAR/CLUB — SPECIFY NAME AND LOCATION	☐ HOTEL — SPECIFY NAME AND LOCATION
☐ HOUSE PARTY — SPECIFY NAME AND LOCATION	☐ WORK/SCHOOL — SPECIFY NAME AND LOCATION	☐ FRIENDS/FAMILY — SPECIFY NAME AND LOCATION
☐ SHOPPING MALL — SPECIFY NAME AND LOCATION	☐ CORRECTIONAL FACILITY — SPECIFY NAME AND LOCATION	☐ OUTDOORS (PARKS, STREETS, ETC) — SPECIFY NAME AND LOCATION
☐ OTHER COMMUNITIES IN MANITOBA — SPECIFY NAME AND LOCATION	☐ OTHER PROVINCE IN CANADA — SPECIFY NAME AND LOCATION	☐ OUTSIDE CANADA — SPECIFY NAME AND LOCATION
☐ OTHER — SPECIFY SETTING, NAME AND LOCATION		

30. **INTERNET WEBSITES / APPS / CHAT ROOM / EMAIL / ETC FOR MEETING SEXUAL PARTNERS** (CHECK ALL THAT APPLY)

☐ PLENTYOFFISH ☐ SQUIRT ☐ TINDER ☐ GRINDR
☐ FACEBOOK ☐ CRAIGSLIST ☐ INSTAGRAM ☐ SNAPCHAT
☐ OTHER (SPECIFY)

31. **ONLINE NAME(S)**

32. **LOCATION OF FIRST PHYSICAL MEETING** — SPECIFY LOCATION

VI. EVIDENCE-BASED RECOMMENDED INTERVENTIONS

>> treatment and interventions > interventions summary

☐ STBBI TESTING RECOMMENDED: GC/CT/HEPATITIS A, B, C/ HIV/SYPHILIS	☐ FOLLOW-UP STBBI TESTING IN 6 MONTHS
☐ ENCOURAGED PERIOD OF ABSTINENCE POST TREATMENT	☐ TEST OF CURE AS PER PROTOCOL
☐ RECOMMENDED IMMUNIZATIONS: HBV/HAV	☐ EDUCATION – CONDOM USE

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VII. TREATMENT INFORMATION

investigation > prescriptions > prescription summary

33. PRESCRIBER NAME	34. TREATMENT FACILITY	35. ☐ PROBABLE PREVIOUS TREATMENT FAILURE
☐ AZITHROMYCIN 1g PO X1 SPECIFY START DATE: YYYY-MM-DD	☐ DOXYCYLINE 100 mg PO BID X 7 DAYS SPECIFY START DATE: YYYY-MM-DD	☐ METRONIDAZOLE 500 mg PO BID X 14 DAYS SPECIFY START DATE: YYYY-MM-DD
☐ CEFIXIME 800 mg PO x1 SPECIFY START DATE: YYYY-MM-DD	☐ AMOXICILLIN 500 mg PO TID X 7 DAYS SPECIFY START DATE: YYYY-MM-DD	☐ OTHER (SPECIFY TREATMENT AND START DATE): SPECIFY START DATE: YYYY-MM-DD
☐ CEFTRIAXONE 250 mg IM x1 SPECIFY START DATE: YYYY-MM-DD	☐ ERYTHROMYCIN 500 mg PO QID X 7 DAYS SPECIFY START DATE: YYYY-MM-DD	

36. **ALLERGIES** (RELEVANT TO TREATMENT, IF ANY)

subject > allergies

SPECIFY

VIII. CONTACTS

investigation > exposure summary > transmission event details

37. NUMBER OF CONTACTS IDENTIFIED BY NAME ➔	SPECIFY NUMBER	38. NUMBER OF ANONYMOUS CONTACTS ➔	SPECIFY NUMBER	39. EARLIEST ANONYMOUS EXPOSURE START DATE ☐ ESTIMATED YYYY-MM-DD

IX. *REPORTER INFORMATION (IF NOT RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE)

40. FORM COMPLETED BY (PRINT NAME)	41. FACILITY NAME/ADDRESS/PHONE#	REPORTER USE ONLY
42. SIGNATURE		
43. FORM COMPLETION DATE YYYY-MM-DD	44. ORGANIZATION (IF APPLICABLE) ◯ WRHA ◯ NRHA ◯ PMH ◯ SH-SS ◯ IERHA ◯ FNIHB ◯ CSC	STAMP HERE

X. * RESPONSIBLE REGIONAL PUBLIC HEALTH AUTHORITY USE ONLY

45. FORM COMPLETED BY (PRINT NAME)	46. SIGNATURE	47. FORM COMPLETION DATE YYYY-MM-DD
48. FORM REVIEWED BY (PRINT NAME)	49. FORM REVIEWED DATE YYYY-MM-DD	RHA USE ONLY
50. INVESTIGATION STATUS ◯ ONGOING ◯ CLOSED TO THE REGION	51. ORGANIZATION ◯ WRHA ◯ NRHA ◯ PMH ◯ SH-SS ◯ IERHA ◯ FNIHB ◯ CSC	STAMP HERE

PLEASE SUBMIT THIS INVESTIGATION FORM BY SECURED FAX OR COURIER TO THE SURVEILLANCE UNIT AT MANITOBA HEALTH AFTER HOURS EMERGENCY PHONE FOR PUBLIC HEALTH ISSUES: (204) 788-8666.

THIS FORM IS ALSO AVAILABLE FOR DOWNLOAD IN A FILLABLE PDF FORMAT AT
http://www.gov.mb.ca/health/publichealth/surveillance/docs/mhsu_6784.pdf

A USER GUIDE FOR COMPLETION OF SURVEILLANCE FORMS FOR REPORTABLE DISEASES AND INSTRUCTIONS FOR THIS FORM ARE AVAILABLE FOR DOWNLOAD AT
http://www.gov.mb.ca/health/publichealth/surveillance/forms.html

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