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

Manitoba Health

Clear Form

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	GENDER IDENTITY (VOLUNTARY, SELF-REPORTED)	AGE (YRS)
○FEMALE ○INTERSEX ○MALE ○UNKNOWN	○CISGENDER (SAME AS SEX AT BIRTH) ○TRANSGENDER PERSON ○DECLINED ○TRANSGENDER MAN ○TRANSGENDER WOMAN ○OTHER (SPECIFY)	(IF DOB NOT COMPLETED)

REGISTRATION NUMBER (FORMER MHSC)	HEALTH NUMBER (PHIN)	ALTERNATE ID
6 DIGITS	9 DIGITS	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)

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CLIENT LAST NAME:		CLIENT FIRST NAME:
PHIN:	: OR	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

STAGING	HEPATITIS B	HEPATITIS C	HIV
ACUTE	○	○	N/A
CHRONIC	○	○	N/A
NEW DIAGNOSIS	N/A	N/A	○
OLD CASE - PREVIOUSLY DIAGNOSED/KNOWN IN MB	○	○	○
PREVIOUS DIAGNOSIS – NEW TO MANITOBA	○	○	○
UNKNOWN/UNDETERMINED	○	○	N/A

COMPLETE FOR SYPHILIS ONLY

SYPHILIS SIGNS/SYMPTOMS (CHECK ALL THAT APPLY)

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

SYPHILIS STAGING

○ PRIMARY
○ SECONDARY
○ EARLY LATENT (LESS THAN 1 YEAR AFTER INFECTION)
○ LATE LATENT (GREATER THAN 1 YEAR AFTER INFECTION)
○ TERTIARY
○ UNKNOWN/UNDETERMINED
○ OLD CASE-PREVIOUSLY DIAGNOSED/ KNOWN IN MB

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

VI. RISK FACTOR INFORMATION (OPTIONAL)

subject > risk factors

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

VII. ADDITIONAL INFORMATION (IF APPLICABLE)

ADDITIONAL UPDATES OR INFORMATION	

FOR LABORATORY CONFIRMED CASES ONLY

HAS CLIENT BEEN INFORMED OF DIAGNOSIS? ○ YES ○ NO ○ PENDING

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

VIII. REPORTER INFORMATION

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

REMINDER: TESTING FOR ALL STBBI IS RECOMMENDED

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

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

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

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

☐ **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):**	☐	☐ 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):**	☐	☐ PUBLIC HEALTH ☐ CASE ☐ HEALTH CARE PROVIDER	**START DATE** **END DATE**
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NAME: **PHIN (IF KNOWN):** **DOB/AGE:** **ADDRESS:** **PHONE:** **ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):**	☐	☐ PUBLIC HEALTH ☐ CASE ☐ HEALTH CARE PROVIDER	**START DATE** **END DATE**

PLEASE SUBMIT THIS FORM 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.

THIS FORM (AND GUIDANCE FOR COMPLETION) IS AVAILABLE FOR DOWNLOAD IN A FILLABLE PDF FORMAT AT:
HTTP://WWW.GOV.MB.CA/HEALTH/PUBLICHEALTH/SURVEILLANCE/FORMS.HTML