

* CASE ACCESSION NUMBER OR CASE INVESTIGATION ID  <input type="checkbox"/> CASE NOT IDENTIFIED	CASE SPECIMEN COLLECTION DATE	TRANSMISSION EVENT ID
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# STBBI CONTACT INVESTIGATION FORM (FOR CONTACTS TO CHLAMYDIA, GONORRHEA, CHANCROID, LGV, HEPATITIS B/C, HIV, AND SYPHILIS INFECTIONS)

## CONTACT FORM

### I. \*INVESTIGATION INFORMATION

1. CONTACT TO A CASE OF	<input type="checkbox"/> CHLAMYDIA	<input type="checkbox"/> GONORRHEA	<input type="checkbox"/> LGV	<input type="checkbox"/> CHANCROID	<input type="checkbox"/> HBV	<input type="checkbox"/> HCV	<input type="checkbox"/> HIV	<input type="checkbox"/> SYPHILIS
2. INVESTIGATION DISPOSITION	<input type="radio"/> FOLLOW-UP COMPLETE <input type="radio"/> UNABLE TO COMPLETE INTERVIEW <input type="radio"/> PENDING							
3. DOES CASE PLAN TO NOTIFY THIS CONTACT HIM/HERSELF?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT ASKED							
4. RESPONSIBLE 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							
5. 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							

### II. \*CLIENT IDENTIFICATION

subject > client details > personal information

6. LAST NAME	7. FIRST NAME	8. SEX <input type="radio"/> FEMALE <input type="radio"/> MALE <input type="radio"/> INTERSEX <input type="radio"/> UNKNOWN
9. ALTERNATE LAST NAME	10. ALTERNATE FIRST NAME	11. DATE OF BIRTH/APPROX. AGE  IF DATE USE YYYY - MM - DD
12. MHSAL REGISTRATION NUMBER  6 DIGITS	13. HEALTH NUMBER (PHIN)  9 DIGITS	14. ALTERNATE ID  SPECIFY TYPE OF ID
15. ADDRESS AT TIME OF TESTING → <input type="checkbox"/> ADDRESS IN FIRST NATION COMMUNITY		16. CITY/TOWN/VILLAGE
17. PROVINCE/TERRITORY	18. POSTAL CODE  A#A #A#	19. PHONE NUMBER  ### - ### - ####
20. ALTERNATE ADDRESS/LOCATING INFORMATION		MHSU USE ONLY
21. PHYSICAL DESCRIPTION IF UNABLE TO IDENTIFY CLIENT		

COMPLETE SECTIONS III AND IV BASED ON INFORMATION PROVIDED BY THE CASE

### III. RISK FACTOR INFORMATION

subject > risk factors

22. CONTACT KNOWN TO BE PREGNANT?	<input type="radio"/> NO <input type="radio"/> UNKNOWN <input type="radio"/> NOT APPLICABLE <input type="radio"/> YES (COMPLETE SECTION VI EDC FROM CONTACT)
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### IV. EXPOSURE DETAILS

investigation > exposure summary > maintain transmission event details

23. MODE OF TRANSMISSION (SELECT ALL THAT APPLY) <input type="checkbox"/> SEXUAL <input type="checkbox"/> BLOODBORNE <input type="checkbox"/> PERINATAL (IF PERINATAL SKIP TO SECTION V)	24. *EXPOSURE START DATE  YYYY-MM-DD <input type="checkbox"/> ESTIMATED	25. EXPOSURE END DATE  YYYY-MM-DD
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#### A. SEXUAL EXPOSURE

>> transmission event details > transmitter role

>> source details > mode of transmission = sexual contact

26. SEXUAL RELATIONSHIP (SELECT ONE ONLY) <input type="radio"/> REGULAR PARTNER <input type="radio"/> CASUAL PARTNER <input type="radio"/> HAS GIVEN GOODS IN EXCHANGE FOR SEX <input type="radio"/> HAS RECEIVED GOODS IN EXCHANGE FOR SEX <input type="radio"/> DECLINED TO ANSWER
27. TYPE OF SEXUAL EXPOSURE (SELECT ALL THAT APPLY) <input type="checkbox"/> VAGINAL SEX <input type="checkbox"/> ANAL SEX <input type="checkbox"/> ORAL SEX
28. FREQUENCY OF SEXUAL CONTACT EVENTS <input type="radio"/> ONCE ONLY <input type="radio"/> 2-10 TIMES <input type="radio"/> 11+ TIMES <input type="radio"/> UNKNOWN <input type="radio"/> DECLINED

#### B. BLOOD AND PERCUTANEOUS EXPOSURES

>> source details > mode of transmission = bloodborne

<input type="checkbox"/> DRUG PARAPHERNALIA SHARING	<input type="checkbox"/> BLOOD-MUCOUS MEMBRANES	<input type="checkbox"/> SHARED TATTOO, BODY PIERCING, SCARIFICATION EQUIPMENT	<input type="checkbox"/> HOUSEHOLD (HEPATITIS B ONLY) >> exposure location > exposure setting type	<input type="checkbox"/> OTHER BLOODBORNE EXPOSURES  SPECIFY
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Page 1 of 3

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**C. EXPOSURE SETTING LOCATION** >> exposure summary > maintain transmission event details > exposure location

29. WHERE / HOW DID YOU FIRST MEET THIS CONTACT (SELECT ONE ONLY FOR NEW CONTACTS DURING EXPOSURE PERIOD)

<input type="checkbox"/> BATHHOUSE	<input type="checkbox"/> BAR/CLUB	<input type="checkbox"/> HOTEL	<input type="checkbox"/> HOUSE PARTY
<input type="checkbox"/> FRIENDS/FAMILY	<input type="checkbox"/> OUTDOORS (PARKS, STREETS, ETC)	<input type="checkbox"/> CORRECTIONAL FACILITY	<input type="checkbox"/> SHOPPING MALL
<input type="checkbox"/> WORK/SCHOOL	<input type="checkbox"/> OTHER COMMUNITIES IN MANITOBA	<input type="checkbox"/> OTHER PROVINCE IN CANADA	<input type="checkbox"/> OUTSIDE CANADA
30. INTERNET WEBSITES/APPS <input type="checkbox"/> FACEBOOK <input type="checkbox"/> GRINDR <input type="checkbox"/> OTHER (SPECIFY)	31. CONTACT'S ONLINE NAME(S)	32. LOCATION OF FIRST PHYSICAL MEETING  SPECIFY LOCATION	<input type="checkbox"/> OTHER SETTING  SPECIFY SETTING, NAME, AND LOCATION

**V. REPORTER INFORMATION FOR CASE INTERVIEW**

33. FORM COMPLETED BY (PRINT NAME)	34. FACILITY NAME/ADDRESS/PHONE #	REPORTER USE ONLY
35. SIGNATURE		
36. FORM COMPLETION DATE YYYY-MM-DD	37. ORGANIZATION (IF APPLICABLE) <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	

COMPLETE THE REST OF THE FORM BASED ON CONTACT FOLLOW-UP

**VI. RISK FACTOR INFORMATION**

subject > risk factors

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:

	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
PREGNANT AT TIME OF INVESTIGATION SPECIFY EDC: YYYY-MM-DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HISTORY OF STBBI(S) (IF KNOWN) SPECIFY INFECTION(S) AND DATE(S)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**VII. SIGNS AND SYMPTOMS**

investigation > signs and symptoms

38. SIGNS AND SYMPTOMS <input type="radio"/> ASYMPTOMATIC <input type="radio"/> SYMPTOMATIC	39. EARLIEST SYMPTOMS ONSET DATE YYYY-MM-DD
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**VIII. TREATMENT INFORMATION**

investigation > prescriptions > prescription summary

40. PRESCRIBER NAME	41. FACILITY NAME
42. CONTACT RECEIVED EPIDEMIOLOGICAL TREATMENT DURING THIS EPISODE? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN	
<input type="checkbox"/> BENZATHINE PENICILLIN G 2.4 million units IM as single dose SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> BENZATHINE PENICILLIN G 2.4 million units IM weekly for 3 doses SPECIFY START DATE: YYYY-MM-DD
<input type="checkbox"/> AZITHROMYCIN 1g PO x1 SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> DOXYCYCLINE 100 mg PO BID x7 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 x7 days SPECIFY START DATE: YYYY-MM-DD
<input type="checkbox"/> CEFTRIAXONE 250 mg IM x1 SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> ERYTHROMYCIN 500 mg PO QID x7 days SPECIFY START DATE: YYYY-MM-DD
43. ALLERGIES (RELEVANT TO TREATMENT)	

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Page 2 of 3

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### IX. EVIDENCE-BASED INTERVENTIONS

>> treatment and interventions > interventions summary

44. <b>RECOMMENDED IMMUNIZATIONS</b>	<input type="checkbox"/> HBV <input type="radio"/> RECOMMENDED <input type="radio"/> ADMINISTERED <input type="radio"/> IMMUNE <input type="radio"/> DECLINED <input type="radio"/> NOT APPLICABLE	
	<input type="checkbox"/> HBIG <input type="radio"/> RECOMMENDED <input type="radio"/> ADMINISTERED <input type="radio"/> IMMUNE <input type="radio"/> DECLINED <input type="radio"/> NOT APPLICABLE	
	<input type="checkbox"/> HAV <input type="radio"/> RECOMMENDED <input type="radio"/> ADMINISTERED <input type="radio"/> IMMUNE <input type="radio"/> DECLINED <input type="radio"/> NOT APPLICABLE	
45. <b>STBBI TESTING RECOMMENDED/COMPLETED</b>	46. <b>LOCATION OF TESTING IF KNOWN</b>	47. <b>DATE (YYYY-MM-DD)</b>
<input type="checkbox"/> CHLAMYDIA <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> GONORRHEA <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> HEPATITIS B <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> HEPATITIS C <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> HIV <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> SYPHILIS <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
48. <input type="checkbox"/> <b>EDUCATION – CONDOM USE</b>		
49. <input type="checkbox"/> <b>OTHER INTERVENTION</b>		
SPECIFY		

### X. \*REPORTER INFORMATION (IF NOT RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE)

50. <b>FORM COMPLETED BY (PRINT NAME)</b>	51. <b>FACILITY NAME/ADDRESS/PHONE#</b>	<b>REPORTER USE ONLY</b>
52. <b>SIGNATURE</b>		
53. <b>FORM COMPLETION DATE</b> YYYY-MM-DD	54. <b>ORGANIZATION (IF APPLICABLE)</b> <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	STAMP HERE

### XI. \*RESPONSIBLE REGIONAL PUBLIC HEALTH AUTHORITY USE ONLY

55. <b>FORM COMPLETED BY (PRINT NAME)</b>	56. <b>SIGNATURE</b>	57. <b>FORM COMPLETION DATE</b> YYYY-MM-DD
58. <b>FORM REVIEWED BY (PRINT NAME)</b>	59. <b>FORM REVIEWED DATE</b> YYYY-MM-DD	<b>RHA USE ONLY</b>
60. <b>INVESTIGATION STATUS</b> <input type="radio"/> ONGOING <input type="radio"/> CLOSED TO THE REGION	61. <b>ORGANIZATION</b> <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	
		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\\_6782.pdf](http://www.gov.mb.ca/health/publichealth/surveillance/docs/mhsu_6782.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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Page 3 of 3