

* CASE ACCESSION NUMBER	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)
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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 <input type="radio"/> FEMALE <input type="radio"/> MALE <input type="radio"/> INTERSEX <input type="radio"/> UNKNOWN		7. GENDER IDENTITY (VOLUNTARY, SELF-REPORTED) <input type="radio"/> CISGENDER (SAME AS SEX AT BIRTH) <input type="radio"/> TRANSGENDER MAN <input type="radio"/> TRANSGENDER WOMAN <input type="radio"/> TRANSGENDER PERSON <input type="radio"/> DECLINED <input type="radio"/> OTHER (SPECIFY IN BOX 8)		8. IF OTHER GENDER IDENTITY, SPECIFY	
9. REGISTRATION NUMBER (FORMER MHSC) 6 DIGITS		10. HEALTH NUMBER (PHIN) 9 DIGITS		11. ALTERNATE ID SPECIFY TYPE OF ID	
12. ADDRESS AT TIME OF DIAGNOSIS → <input type="checkbox"/> ADDRESS IN FIRST NATION COMMUNITY				13. CITY/TOWN/VILLAGE	
14. PROVINCE/TERRITORY		15. POSTAL CODE A#A #A#		16. PHONE NUMBER ### - ### - ####	
17. ETHNIC ORIGIN (VOLUNTARY, SELF-REPORTED – CHOOSE ONE ONLY) <input type="radio"/> AFRICAN <input type="radio"/> EUROPEAN (INCLUDES EASTERN EUROPE) <input type="radio"/> NORTH AMERICAN INDIGENOUS <input type="radio"/> DECLINED <input type="radio"/> ASIAN (INCLUDES MIDDLE EAST, PHILIPPINES) <input type="radio"/> LATIN, CENTRAL AND SOUTH AMERICAN (INCLUDES MEXICO) <input type="radio"/> OCEANIA (INCLUDES PACIFIC ISLANDS) <input type="radio"/> NOT ASKED <input type="radio"/> CARIBBEAN <input type="radio"/> NORTH AMERICAN (INCLUDES CANADA, USA) <input type="radio"/> UNKNOWN					
18. INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, SELF-REPORTED) <input type="radio"/> FIRST NATIONS <input type="radio"/> MÉTIS <input type="radio"/> INUIT <input type="radio"/> NOT ASKED <input type="radio"/> DECLINED		19. FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED) <input type="radio"/> STATUS <input type="radio"/> NON-STATUS <input type="radio"/> NOT ASKED <input type="radio"/> DECLINED		MHSU USE ONLY	
20. ALTERNATE LOCATION INFORMATION (IF ANY)					

II. INVESTIGATION INFORMATION

21. *INVESTIGATION DISPOSITION	<input type="radio"/> FOLLOW-UP COMPLETE <input type="radio"/> UNABLE TO COMPLETE INTERVIEW <input type="radio"/> PENDING
22. *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
23. 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

III. *INFECTION INFORMATION

investigation > subject summary > STBBI encounter group

24. CASE CLASSIFICATION		<input type="radio"/> LAB CONFIRMED		<input type="radio"/> PROBABLE		<input type="radio"/> NOT A CASE	
<input type="checkbox"/> CHLAMYDIA SPECIFY SPECIMEN COLLECTION DATE → YYYY-MM-DD	<input type="checkbox"/> GONORRHEA SPECIFY SPECIMEN COLLECTION DATE → YYYY-MM-DD	<input type="checkbox"/> LGV SPECIFY SPECIMEN COLLECTION DATE → YYYY-MM-DD	<input type="checkbox"/> CHANCROID SPECIFY SPECIMEN COLLECTION DATE → YYYY-MM-DD				
25. PRESENTATION (SITES) investigation > investigation details > disease summary > update > disease event history							
<input type="checkbox"/> GENITAL	<input type="checkbox"/> PHARYNGEAL	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> OTHER MALE GENITAL ORGANS	<input type="checkbox"/> PELVIC INFLAMMATORY DISEASE	26. <input type="checkbox"/> OTHER		
<input type="checkbox"/> RECTAL	<input type="checkbox"/> EYE	<input type="checkbox"/> LYMPH NODES	<input type="checkbox"/> PNEUMONIA	SPECIFY			

IV. SIGNS AND SYMPTOMS

investigation > signs and symptoms

27. SIGNS AND SYMPTOMS <input type="radio"/> ASYMPTOMATIC <input type="radio"/> SYMPTOMATIC	28. EARLIEST SYMPTOMS ONSET DATE YYYY-MM-DD
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* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

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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 <small>SPECIFY EDC YYYY-MM-DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CONTACT TO A NEW OR PREVIOUSLY DIAGNOSED CASE <small>SPECIFY INFECTION AND DATE YYYY-MM-DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HAS GIVEN GOODS IN EXCHANGE FOR SEX	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HAS RECEIVED GOODS IN EXCHANGE FOR SEX	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HISTORY OF STI <small>SPECIFY INFECTION(S) AND DATE(S)</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NEW SEX PARTNER WITHIN LAST 3 MONTHS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEXUAL ASSAULT (NON-CONSENSUAL SEX)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SUBSTANCE USE - ALCOHOL USE DURING SEXUAL EXPOSURE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SUBSTANCE USE – OTHER THAN ALCOHOL DURING SEXUAL EXPOSURE <small>SPECIFY SUBSTANCE</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TYPE OF SEXUAL EXPOSURE: ANAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TYPE OF SEXUAL EXPOSURE: ORAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TYPE OF SEXUAL EXPOSURE: VAGINAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER RISK FACTOR <small>SPECIFY</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)

<input type="checkbox"/> BATHHOUSE <small>SPECIFY NAME AND LOCATION</small>	<input type="checkbox"/> BAR/CLUB <small>SPECIFY NAME AND LOCATION</small>	<input type="checkbox"/> HOTEL <small>SPECIFY NAME AND LOCATION</small>
<input type="checkbox"/> HOUSE PARTY <small>SPECIFY NAME AND LOCATION</small>	<input type="checkbox"/> WORK/SCHOOL <small>SPECIFY NAME AND LOCATION</small>	<input type="checkbox"/> FRIENDS/FAMILY <small>SPECIFY NAME AND LOCATION</small>
<input type="checkbox"/> SHOPPING MALL <small>SPECIFY NAME AND LOCATION</small>	<input type="checkbox"/> CORRECTIONAL FACILITY <small>SPECIFY NAME AND LOCATION</small>	<input type="checkbox"/> OUTDOORS (PARKS, STREETS, ETC) <small>SPECIFY NAME AND LOCATION</small>
<input type="checkbox"/> OTHER COMMUNITIES IN MANITOBA <small>SPECIFY NAME AND LOCATION</small>	<input type="checkbox"/> OTHER PROVINCE IN CANADA <small>SPECIFY NAME AND LOCATION</small>	<input type="checkbox"/> OUTSIDE CANADA <small>SPECIFY NAME AND LOCATION</small>
<input type="checkbox"/> OTHER <small>SPECIFY SETTING, NAME AND LOCATION</small>		

30. INTERNET WEBSITES / APPS / CHAT ROOM / EMAIL / ETC FOR MEETING SEXUAL PARTNERS (CHECK ALL THAT APPLY) <input type="checkbox"/> PLENTYOFFISH <input type="checkbox"/> SQUIRT <input type="checkbox"/> TINDER <input type="checkbox"/> GRINDR <input type="checkbox"/> FACEBOOK <input type="checkbox"/> CRAIGSLIST <input type="checkbox"/> INSTAGRAM <input type="checkbox"/> SNAPCHAT <input type="checkbox"/> OTHER (SPECIFY)	31. ONLINE NAME(S)	32. LOCATION OF FIRST PHYSICAL MEETING <small>SPECIFY LOCATION</small>
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VI. EVIDENCE-BASED RECOMMENDED INTERVENTIONS

>> treatment and interventions > interventions summary

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

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VII. TREATMENT INFORMATION

investigation > prescriptions > prescription summary

33. PRESCRIBER NAME	34. TREATMENT FACILITY	35. <input type="checkbox"/> PROBABLE PREVIOUS TREATMENT FAILURE
<input type="checkbox"/> AZITHROMYCIN 1g PO X1 <small>SPECIFY START DATE: YYYY-MM-DD</small>	<input type="checkbox"/> DOXYCYCLINE 100 mg PO BID X 7 DAYS <small>SPECIFY START DATE: YYYY-MM-DD</small>	<input type="checkbox"/> METRONIDAZOLE 500 mg PO BID X 14 DAYS <small>SPECIFY START DATE: YYYY-MM-DD</small>
<input type="checkbox"/> CEFIXIME 800 mg PO x1 <small>SPECIFY START DATE: YYYY-MM-DD</small>	<input type="checkbox"/> AMOXICILLIN 500 mg PO TID X 7 DAYS <small>SPECIFY START DATE: YYYY-MM-DD</small>	<input type="checkbox"/> OTHER (SPECIFY TREATMENT AND START DATE): <small>SPECIFY START DATE: YYYY-MM-DD</small>
<input type="checkbox"/> CEFTRIAXONE 250 mg IM x1 <small>SPECIFY START DATE: YYYY-MM-DD</small>	<input type="checkbox"/> ERYTHROMYCIN 500 mg PO QID X 7 DAYS <small>SPECIFY START DATE: YYYY-MM-DD</small>	
36. ALLERGIES (RELEVANT TO TREATMENT, IF ANY)		subject > allergies <small>SPECIFY</small>

VIII. CONTACTS

investigation > exposure summary > transmission event details

37. NUMBER OF CONTACTS IDENTIFIED BY NAME → <small>SPECIFY NUMBER</small>	38. NUMBER OF ANONYMOUS CONTACTS → <small>SPECIFY NUMBER</small>	39. EARLIEST ANONYMOUS EXPOSURE START DATE <input type="checkbox"/> ESTIMATED <small>YYYY-MM-DD</small>
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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 <small>YYYY-MM-DD</small>	44. ORGANIZATION (IF APPLICABLE) <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

X. * RESPONSIBLE REGIONAL PUBLIC HEALTH AUTHORITY USE ONLY

45. FORM COMPLETED BY (PRINT NAME)	46. SIGNATURE	47. FORM COMPLETION DATE <small>YYYY-MM-DD</small>
48. FORM REVIEWED BY (PRINT NAME)	49. FORM REVIEWED DATE <small>YYYY-MM-DD</small>	RHA USE ONLY
50. INVESTIGATION STATUS <input type="radio"/> ONGOING <input type="radio"/> CLOSED TO THE REGION	51. 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	
		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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