CASE ACCESSION NUMBER

ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

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 O FEMALE O MALE O INTERSEX O UNKNOWN	7.*GENDER IDENTITY (VOLUNTARY, SELF-REPORTED) O CISGENDER (SAME AS SEX AT BIRTH) O TRANSGENDER MAN O TRANSGENDER WOMAN O TRANSGENDER PERSON O DECLINED O OTHER (SPECIFY IN BOX 8)	8.IF OTHER GENDER IDENTITY, SPECIFY
9.*REGISTRATION NUMBER (FORMER MHSC) 6 DIGITS | UPPERCASE ALPHANUMERIC	10.*HEALTH NUMBER (PHIN) 9 DIGITS	11.ALTERNATE ID 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 A#A #A#	16.*PHONE NUMBER ### - ### - ####

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

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

18.*INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, SELF-REPORTED) O FIRST NATIONS O MÉTIS O INUIT O NOT ASKED O DECLINED	19.*FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED) O STATUS O NON-STATUS O NOT ASKED O DECLINED	MHSU USE ONLY
20.ALTERNATE LOCATION INFORMATION (IF ANY)		

II. INVESTIGATION INFORMATION

investigation > investigation details > disease summary > disease event

21.*INVESTIGATION DISPOSITION	O FOLLOW-UP COMPLETE O FOLLOW-UP COMPLETE BY OTHER PROVIDER, NO PH FOLLOW-UP O UNABLE TO LOCATE
22.*PRIMARY INVESTIGATOR ORGANIZATION	O WRHA O NRHA O PMH O SH-SS O IERHA O FNIHB O 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 O LAB CONFIRMED O PROBABLE (FOR "LGV" ONLY) O NOT A CASE

☐ CHLAMYDIA SPECIFY SPECIMEN COLLECTION DATE ➔	YYYY-MM-DD	☐ GONORRHEA SPECIFY SPECIMEN COLLECTION DATE ➔	YYYY-MM-DD	☐ LGV SPECIFY SPECIMEN COLLECTION DATE ➔	YYYY-MM-DD	☐ CHANCROID 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	26. ☐ OTHER SPECIFY
☐ RECTAL	☐ EYE	☐ LYMPH NODES	☐ PNEUMONIA		

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

CSSE ACCESSION NUMBER	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

Manitoba Health, Seniors and Long-Term Care

IV. SIGNS AND SYMPTOMS

investigation > signs and symptoms

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

V. RISK FACTOR INFORMATION

subject > risk factors

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED: REQUIRED RISK FACTORS INDICATED WITH * MUST HAVE A RESPONSE DOCUMENTED IN PHIMS	YES	NO	UNKNOWN	DECLINED TO ANSWER	NOT ASKED
*PREGNANT AT TIME OF DIAGNOSIS SPECIFY EDC YYYY-MM-DD	○	○	○	○	○
BORN TO INFECTED MOTHER/ BIRTH PARENT	○	○	○	○	○
HOUSING UNSTABLE	○	○	○	○	○
MSM	○	○	○	○	○
SEXUAL PARTNER AT RISK	○	○	○	○	○
CONTACT TO NEW OR PREVIOUSLY DIAGNOSED CASE SPECIFY INFECTION AND DATE YYYY-MM-DD	○	○	○	○	○
OTHER RISK FACTOR (FOR LGV OR CHANCROID REFER TO PROTOCOL) SPECIFY	○	○	○	○	○

VI. EVIDENCE-BASED RECOMMENDED INTERVENTIONS

treatment & interventions > interventions summary

☐ PREVENTION EDUCATION/COUNSELLING AS PER DISEASE PROTOCOL	☐ REFERRAL FOR TREATMENT:(SPECIFY-INCLUDING REFERRAL FOR HIV PREP OR PEP
☐ IMMUNIZATION RECOMMENDED O HBV O HAV O HPV O MPOX	☐ STBBI TESTING RECOMMENDED o CT/GC o SYPHILIS o HBV o HCV o HIV
☐ AWAITING MEDICAL INFORMATION OR HISTORY	☐ TEST OF CURE RECOMMENDED
☐ TREATMENT RECOMMENDED	

VII. TREATMENT INFORMATION

For Gonorrhea and Chlamydia: If treatment is already documented in a provider form investigation it does not need to be re-entered into the disease investigation

investigation >medications > medication summary

29. PRESCRIBER NAME	30. TREATMENT FACILITY	31. ☐ 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 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	

33. ALLERGIES (RELEVANT TO TREATMENT, IF ANY)

subject > allergies

SPECIFY

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

VIII. CONTACTS

investigation > exposure summary > transmission event details

34. NUMBER OF CONTACTS IDENTIFIED BY NAME ➔	SPECIFY NUMBER	35. NUMBER OF ANONYMOUS CONTACTS ➔	SPECIFY NUMBER	36. EARLIEST ANONYMOUS EXPOSURE START DATE YYYY-MM-DD ☐ ESTIMATED

IX.*REPORTER INFORMATION

37. FORM COMPLETED BY (PRINT NAME)		38. FACILITY NAME/ADDRESS/PHONE#	REPORTER USE ONLY
39. FORM COMPLETION DATE YYYY-MM-DD	40. INVESTIGATION STATUS ☐ ONGOING ☐ CLOSED TO THE REGION	41. ORGANIZATION (IF APPLICABLE) ○ 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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