



Infection Treatment Reporting Form

Health Care Provider:			
Phone:		Fax:	
Client Demographics			
Legal Name:		Date of Birth:	
Address:		Phone Number:	
Testing Details			
Infection: <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> GONORRHEA			
Date of Testing:		Date of Diagnosis:	
Reason for testing: <input type="checkbox"/> Routine <input type="checkbox"/> Prenatal <input type="checkbox"/> Contact <input type="checkbox"/> Other (specify)			
Symptomatic: <input type="checkbox"/>	If yes, specify:		Onset Date:
Treatment Details			
<small>**For alternative treatment during pregnancy, please refer to the Canadian Guidelines on Sexually Transmitted Infections**</small>			
<input type="checkbox"/> Azithromycin - 1 gram P.O. STAT		<input type="checkbox"/> Doxycycline - 100 mg P.O. BID x 7 Days	
<input type="checkbox"/> Ceftriaxone (Rocephin) 250 mg IM, STAT		<input type="checkbox"/> Cefixime 800mg P.O. single dose <input type="checkbox"/> Other:	
Treatment Date:		Proper Medication Use Discussed: <input type="checkbox"/>	
<input type="checkbox"/> Advised to abstain from sexual contact (ALL TYPES) for 7 days after treatment is completed (i.e. after completion of a multiple-dose or single-dose treatment)			
<input type="checkbox"/> Contacts notified by Case			
<input type="checkbox"/> Test of Cure Recommended/Booked			
<input type="checkbox"/> Health Teaching completed by Health Care Provider			
<small>**PLEASE NOTE: Health teaching and follow up will be completed by Lambton Public Health if not done by Health Care Provider**</small>			
Health Care Provider Signature: Health Care Provider name (please print):			Date:
Documentation Key	<input checked="" type="checkbox"/> =Yes	<input checked="" type="checkbox"/> =No	<input type="checkbox"/> =Not asked/reviewed