Lambton Public Health

Infection Treatment Reporting Form

Health Care Provider:	
Phone:	**Fax:**

Client Demographics

Legal Name:	Date of Birth:
Address:	Phone:

Testing Details

Date of Testing:	Date of Diagnosis:	
Reason for testing: ☐ Routine ☐ Prenatal ☐ Contact ☐ Follow-up Serology ☐ Other (specify)		
Symptomatic: ☐	If yes, specify:	Onset Date:

Pregnancy Status

☐ N/A ☐ Pregnant ☐ Non-Pregnant ☐ unknown	Trimester: ☐ 1st ☐ 2nd ☐ 3rd	LMP:

Staging &Treatment Details

SYPHILIS STAGE (<1 yr): ☐ PRIMARY ☐ SECONDARY ☐ EARLY LATENT

Preferred Treatment	**Alternative Treatment/ Penicillin-Allergy**
☐ **Penicillin G** (Bicillin L-A) 2.4 million units IM, **single dose** **Treatment Date:**	☐ **Doxycycline** 100 mg PO BID for **14 days** **Treatment Date:**

☐ Advised/booked for recommended follow-up **serology at 3, 6, 12 months post treatment**
(☐ HIV co-infection: at 3, 6, 12, 24 months and then yearly thereafter; ☐ Pregnancy: monthly until delivery and then 1, 3, 6, 12 months post treatment)

SYPHILIS STAGE (>1 yr): ☐ LATE LATENT ☐ LATENT OF UNKNOWN DURATION

Preferred Treatment	**Alternative Treatment/ Penicillin-Allergy**
☐ **Penicillin G** (Bicillin L-A) 2.4 million units IM, **weekly x 3 doses** **Treatment Date:** **Dose #1:** **Dose #2:** **Dose #3:**	☐ **Doxycycline** 100 mg PO BID for **28 days** **Treatment Date:**

☐ Advised/booked for recommended follow-up **serology at 12, 24 months post treatment**
(☐ HIV co-infection: at 3, 6, 12, 24 months and then yearly thereafter; ☐ Pregnancy: At delivery and then 12, 24 months)

SYPHILIS STAGE: ☐ NEUROSYPHILIS ☐ CONGENITAL ☐ OTHER (please specify)

☐ **Treatment (please specify):**
Treatment Date:
Follow-up serology advised/booked (specify):

☐ Advised/booked for recommend follow up serology for neurosyphilis at 6, 12, 24 months post treatment

Education & Referrals

☐ 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)

☐ Contacts notified by Case

☐ Health Teaching completed by Health Care Provider

☐ Referral, if made please indicate:

Health Care Provider Signature: Health Care Provider name (please print):	Date:

Documentation Key	☑=Yes	☒=No	☐=Not asked/reviewed

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Infection Treatment Reporting Form

Health Care Provider:	
Phone:	**Fax:**

Client Demographics	
Legal Name:	Date of Birth:
Address:	Phone Number:

Testing Details		
Infection: ☐ CHLAMYDIA ☐ GONORRHEA		
Date of Testing:	Date of Diagnosis:	
Reason for testing: ☐ Routine ☐ Prenatal ☐ Contact ☐ Other (specify)		
Symptomatic: ☐	If yes, specify:	Onset Date:

Treatment Details ****For alternative treatment during pregnancy, please refer to the Canadian Guidelines on Sexually Transmitted Infections****	
☐ **Azithromycin - 1 gram P.O. STAT**	☐ **Doxycycline - 100 mg P.O. BID x 7 Days**
☐ **Ceftriaxone (Rocephin) 500 mg IM, STAT**	☐ **Cefixime 800mg P.O. single dose** ☐ **Other:**
Treatment Date:	Proper Medication Use Discussed:☐

☐ **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)

☐ **Contacts notified by Case**

☐ **Test of Cure Recommended/Booked**

☐ **Health Teaching completed by Health Care Provider**

PLEASE NOTE: Health teaching and follow up will be completed by Lambton Public Health if not done by Health Care Provider

Health Care Provider Signature: Health Care Provider name (please print):	Date:

Documentation Key	☑=Yes	☒=No	☐=Not asked/reviewed