

**Request for Information**  
**Reportable/ Communicable Disease**  
*Under Health Protection and Promotion Act*

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**Chlamydia**

Date:

To:

Fax No:

From:

Tel:

Fax No: 1-855-934-5463

**PLEASE COMPLETE FORM AND RETURN AS SOON AS POSSIBLE**

Client : (D.O.B) :

Client Demographics correct?  
 Yes  No

Address :

*Please provide a contact number that the client can be reached at. A cell phone number is preferred.*

Tel# : \_\_\_\_\_ Cell#: \_\_\_\_\_

**Reason for Testing:**

- Routine
- Symptomatic, Symptoms: \_\_\_\_\_
- STI Contact
- Prenatal screen E.D.D: \_\_\_\_\_

Patient advised of result  Yes  No

Patient advised to notify possible contacts from the last 60 Days prior to diagnosis or onset of symptoms?  Yes  No

**First Line Treatment (It is not best practice to treat for Gonorrhea if test result returns negative):**

- Azithromycin 1gm P.O. date: \_\_\_/\_\_\_/\_\_\_ ( If poor compliance is expected)
- Doxycycline 100 mg P.O. BID x7 days date: \_\_\_/\_\_\_/\_\_\_

**Alternative Treatment: see Canadian Guidelines for STI Treatment:**

<http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/index-eng.php>

Other: \_\_\_\_\_ date: \_\_\_/\_\_\_/\_\_\_

Was your patient advised that Public Health will contact them?  Yes  No  Unknown

Have you advised the client to refrain from having unprotected sexual activity x 1 week after client and partner(s) have completed treatment?  Yes  No  Unknown

A PHN will attempt to contact client for counselling, partner notification and future infection prevention. We will also confirm that the client took and tolerated the medication you prescribed. We will discuss test of cure and other possible STI testing if appropriate post treatment.

***Condom use is always important for ongoing STI protection.***

Health care practitioner: \_\_\_\_\_ Date: \_\_\_\_\_