

**SURVEILLANCE LETTER FOR:**

☐

**CHLAMYDIA**

☐

**GONORRHEA**

Dear \_\_\_\_\_,

We have received a positive lab report dated \_\_\_\_\_ on the following client. Please complete this form and fax back within one week to: 613 968-1482.

**Name:** \_\_\_\_\_ **Date Of Birth:** (YY/MM/DD) \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_  
Home Cell Work

**REASON(S) FOR TESTING:**

- ☐ Routine Screening ☐ Symptoms ☐ Contact Tracing ☐ Immigration Screening  
☐ Prenatal Screening (EDD: \_\_\_\_\_) ☐ Other \_\_\_\_\_  
YY / MM / DD

**SIGNS AND SYMPTOMS:**

- ☐ Asymptomatic ☐ Abdominal Pain ☐ Discharge Purulent  
☐ Urethral Irritation ☐ Urination Difficulty (Dysuria) ☐ Urine, Bloody (Hematuria)  
☐ Urine, Frequency ☐ Rectal Pain ☐ Painful Intercourse (Dyspareunia)  
☐ Abnormal Vaginal Bleeding ☐ Other / Complications \_\_\_\_\_

**CHLAMYDIA:**

√	Treatment	Dose	Unit	Frequency	Route	Treatment Date YY / MM / DD
	Azithromycin (Zithromax)	1	g	single dose	PO	
	Doxycycline (Vibramycin)	100	mg	bid x7 days	PO	
	Ofloxacin	300	mg	bid x7 days	PO	
	Erythromycin	2	g	divided doses x7 days	PO	
	Other					

**GONORRHEA:**

√	Treatment	Treatment Date YY / MM / DD
	Ceftriaxone 250 mg IM plus Azithromycin 1g PO **Recommended first line treatment**	

***If the client is allergic to Ceftriaxone or Azithromycin, please contact Public Health to discuss alternative options. A test of cure is required if an alternate treatment is used.***

**NOTE:**

**It is preferred to conduct culture for GC TOC ≥ four (4) days post treatment.**

**If using Nucleic Acid Amplification Test (NAAT) for TOC, perform one (1) month post treatment.**

Advise your client to abstain from having sexual activity for 7 days following treatment. Please advise client that health unit will provide partner notification, and that all partners within 60 days prior to diagnosis must be notified. If the client has had no partners within 60 days then the last sexual partner is notified.

If you have any questions or would like to order **free STI medications** for this client, please call (613) 966-5500 ext.243. To order **free hepatitis A** vaccine (available for persons with chronic liver disease; including hepatitis C, injection drug users and men who have sex with men) for this client, and/or **free hepatitis B vaccine** for this client and sexual contact(s), fax vaccine order form to (613) 966-1813.

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

YY / MM / DD

**SH-32**