Notification of Sexually Transmitted Disease – Confidential

Manitoba Health Sexually Transmitted Disease Control
4th Floor - 300 Carlton Street
Winnipeg, Manitoba
R3B 3M9
(204) 788-6736

Regn. No. (Leave Blank)

NAME (SURNAME) | GIVEN NAME | DATE OF BIRTH (Y M D) | SEX ☐ FEMALE ☐ MALE

ADDRESS | POSTAL CODE | TELEPHONE: HOME / WORK

☐ MARRIED/COMMON LAW SPOUSE'S FIRST NAME ▶ | ☐ MAIDEN NAME (IF APPLICABLE) ▶

DATE TESTED: (Y M D)
ONSET: (Y M D)

☐ GONORRHEA ☐ CHLAMYDIA

TYPE: ☐ GENITO-URINARY ☐ OTHER (SPECIFY) _____

CLINICAL FINDINGS (DESCRIBE) _____

DURATION OF SYMPTOMS _____

LABORATORY TESTS:

SMEAR ☐ POS ☐ NEG CULTURE ☐ POS ☐ NEG

GONOZYME ☐ POS ☐ NEG CHLAMDIAZYME ☐ POS ☐ NEG

HAS A BLOOD TEST BEEN TAKEN FOR SYPHILIS ☐ YES ☐ NO

TREATMENT GIVEN (SPECIFY) _____

DATE (Y M D)

PREVIOUS TREATMENT FOR: GONORRHEA ☐ YES ☐ NO

CHLAMYDIA ☐ YES ☐ NO

DATE (Y M D)

☐ SYPHILIS

TYPE: ☐ PRIMARY ☐ SECONDARY ☐ EARLY LATENT ☐ LATE LATENT

☐ CARDIOVASCULAR ☐ NEUROSYPHILIS ☐ CONGENITAL

TREATMENT GIVEN (SPECIFY) _____

DATE (Y M D)

DIAGNOSIS BASED ON:

DARKFIELD DFA-TP ☐ POS ☐ NEG SCREEN ☐ POS ☐ NEG

CONFIRMATORY ☐ POS ☐ NEG REFERENCE ☐ POS ☐ NEG

CEREBROSPINAL FLUID ☐ POS ☐ NEG ☐ NOT DONE

CLINICAL FINDINGS (DESCRIBE) _____

PREVIOUS TREATMENT FOR SYPHILIS ☐ YES ☐ NO

BY WHOM _____ DATE (Y M D)

OTHER SEXUALLY TRANSMITTED DISEASES

☐ **AIDS** ☐ **CHANCROID** ☐ **LGV**

DO YOU WISH: ☐ **CONSULTATIVE SERVICE** ☐ **NOTIFICATION FORMS** ☐ **PATIENT LITERATURE**

PHYSICIAN'S SIGNATURE: ADDRESS

PLEASE RETURN ALL FOUR COPIES

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NAME | MAIDEN NAME | TELEPHONE HOME / WORK

ADDRESS | POSTAL CODE | DATE OF BIRTH / AGE | FEMALE ☐ MALE ☐

MARITAL STATUS: ☐ MARRIED/CL ☐ SINGLE ☐ OTHER _____ WHERE LIVING: ☐ PARENTS ☐ INFORMANT ☐ OTHER _____

OCCUPATION _____ PLACE OF EMPLOYMENT _____

RELATIONSHIP: ☐ MARITAL ☐ PICK-UP ☐ FRIEND ☐ PROSTITUTE FEE _____

CHARACTERISTICS: HEIGHT _____ WEIGHT _____ EYE COLOUR _____ HAIR _____ COMPLEXION _____ OTHER _____

PLACE OF MEETING _____ PLACE OF EXPOSURE _____ **DATE OF EXPOSURE** (FIRST)_____ TO _____

FREQUENCY OF SEX CONTACT _____ ☐ TYPE O-G ☐ G-G ☐ R-G

REMARKS: _____

FOR PUBLIC HEALTH USE ONLY DATE _____ MONTH _____

NAME OF INFORMANT _____ PAGE _____

ADDRESS _____ DATE/TYPE SPECIMEN _____

☐ GONORRHEA ☐ CHLAMYDIA ☐ SYPHILIS ☐ OTHER _____

RESULT OF EXAMINATION

DATE	STS BLOOD/CSF	GC SMEAR / CULTURE	CHLAMYDIA TEST	CLINICAL FINDINGS	TREATMENT

EXAMINED BY: _____ SUBMITTED BY: _____

COMMENTS:

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EXAMINED BY: _____ SUBMITTED BY: _____

COMMENTS:

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