

# MHSU 6781 - PROVIDER REPORT FORM FOR SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS (STBBI) AND STI TREATMENT



NEW REPORT _____ (YYYY-MM-DD)	UPDATED REPORT _____ (YYYY-MM-DD)
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## I. CLIENT IDENTIFICATION

subject > client details > personal information

LAST NAME		FIRST NAME		DATE OF BIRTH (YYYY-MM-DD)		
SEX FEMALE INTERSEX MALE UNKNOWN		GENDER IDENTITY (VOLUNTARY, SELF-REPORTED) CISGENDER (SAME AS SEX AT BIRTH) TRANSGENDER PERSON TRANSGENDER MAN TRANSGENDER WOMAN DECLINED OTHER (SPECIFY)			AGE (YRS)  (IF DOB NOT COMPLETED)	
REGISTRATION NUMBER (FORMER MHSC)  6 DIGITS   UPPERCASE ALPHANUMERIC			HEALTH NUMBER (PHIN)  9 DIGITS		ALTERNATE ID  SPECIFY TYPE OF ID	
ADDRESS AT TIME OF DIAGNOSIS → ADDRESS IN FIRST NATION COMMUNITY					CITY/TOWN/VILLAGE	
PROVINCE/TERRITORY		POSTAL CODE (A# A# A#)		PHONE NUMBER (### - ### - ####)		
ALTERNATE IDENTIFYING OR LOCATION INFORMATION (IF ANY. E.G. ALTERNATE NAME, SOCIAL MEDIA, ALTERNATE ADDRESS)						
PREVIOUS NON-NOMINAL CODE(S) OR NAME(S) USED FOR POSITIVE HIV TESTS IF APPLICABLE (SPECIFY COUNTRY/PROVINCE, CODE/NAME, AND DATES YYYY-MM-DD IF KNOWN)						

## II. PREGNANCY

subject > risk factors

IS CLIENT PREGNANT/POST PARTUM?	YES	EDD OR DELIVERY DATE:	(YYYY-MM-DD)	NO	UNKNOWN
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## III. INFECTION INFORMATION

investigation > investigation details > disease summary > update > disease event history

REASON FOR REPORTING:		LAB CONFIRMED INFECTION(S) (SPECIFY BELOW)			STBBI TREATMENT PROVIDED (CONTACTS OR CLINICAL CASES) (TEST RESULTS PENDING OR NOT DONE) PROCEED TO TREATMENT INFORMATION			
LAB CONFIRMED INFECTIONS (CHECK ALL THAT APPLY)		CHLAMYDIA GONORRHEA	CHANCROID	LGV	HEPATITIS B	HEPATITIS C	HIV	SYPHILIS
SPECIMEN COLLECTION DATE (YYYY-MM-DD)								

## IV. TREATMENT INFORMATION

investigation > prescriptions > prescription summary

PRESCRIBER NAME		PRESCRIBER/TREATMENT FACILITY			
SYPHILIS	BENZATHINE PENICILLIN G 2.4 million units, IM, 1 dose START DATE (YYYY-MM-DD):	BENZATHINE PENICILLIN G 2.4 million units, IM weekly, 2 doses START DATE (YYYY-MM-DD):	BENZATHINE PENICILLIN G 2.4 million units, IM weekly, 3 doses START DATE (YYYY-MM-DD):	CEFTRIAXONE 1 g daily x 10 days, IV / IM (circle one) START DATE (YYYY-MM-DD):	
	CEFTRIAXONE 2 g daily x 10 days, IV / IM (circle one) START DATE (YYYY-MM-DD):	DOXYCYCLINE 100 mg PO BID x 14 days START DATE (YYYY-MM-DD):	DOXYCYCLINE 100 mg PO BID x 28 days START DATE (YYYY-MM-DD):	PENICILLIN G 3 - 4 M IV Q4H x 10-14 days START DATE (YYYY-MM-DD):	
CHLAMYDIA, GONORRHEA	AZITHROMYCIN 1g PO, single dose START DATE (YYYY-MM-DD):	CEFIXIME 800 mg PO, single dose START DATE (YYYY-MM-DD):	DOXYCYCLINE 100 mg PO BID x 7 days START DATE (YYYY-MM-DD):	METRONIDAZOLE 500 mg PO BID x 14 days START DATE (YYYY-MM-DD):	
	AMOXICILLIN 500 mg PO TID x 7 days START DATE (YYYY-MM-DD):	CEFTRIAXONE 250 mg IM, single dose START DATE (YYYY-MM-DD):	ERYTHROMYCIN 500 mg PO QID x 7 days START DATE (YYYY-MM-DD):		
OTHER TREATMENT (LGV   OTHER INFECTION, IF APPLICABLE)	SPECIFY:				START DATE (YYYY-MM-DD):
UPDATE TO PREVIOUS INFORMATION SUBMITTED	SPECIFY DETAILS ON ANY CHANGE TO SYPHILIS TREATMENT PLAN (E.G. CLIENT DID NOT ATTEND FOR ANOTHER DOSE)				
	PREVIOUSLY REPORTED TREATMENT PRIOR TO POSITIVE TEST – PROVIDE FORM COMPLETION DATE (YYYY-MM-DD)				

CLIENT LAST NAME:	CLIENT FIRST NAME:	
PHIN:	DOB:	(YYYY-MM-DD)

**V. PRESENTATION/STAGING (FOR LAB CONFIRMED CASES ONLY)**

investigation > investigation details > investigation information

<b>COMPLETE FOR CHLAMYDIA, GONORRHEA, LGV, CHANCROID ONLY</b>				
<b>PRESENTATION</b>				
ARTHRITIS	GENITAL	PHARYNGEAL	RECTAL/ANAL	OTHER (SPECIFY):
EYE	PELVIC INFLAMMATORY DISEASE	PNEUMONIA		
<b>COMPLETE FOR HEPATITIS B, HEPATITIS C, AND HIV ONLY</b>				
<b>HEPATITIS B STAGING</b>		<b>HEPATITIS C STAGING</b>		<b>HIV STAGING</b>
ACUTE	CHRONIC	ACUTE (INCLUDES RE-INFECTIONS)	CHRONIC (INCLUDES RE-INFECTIONS)	NEW DIAGNOSIS
PERINATAL CASE	PREVIOUS DIAGNOSIS- CHRONIC	PERINATAL CASE	RESOLVED	PERINATAL CASE
UNKNOWN/UNDETERMINED		PREVIOUS DIAGNOSIS- CHRONIC	PREVIOUS DIAGNOSIS	PREVIOUS DIAGNOSIS- NEW TO MANITOBA
		PREVIOUS DIAGNOSIS	UNKNOWN/UNDETERMINED	OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MANITOBA
		UNKNOWN/UNDETERMINED		UNKNOWN/UNDETERMINED
<b>COMPLETE FOR SYPHILIS ONLY</b>				
<b>SYPHILIS SIGNS/SYMPTOMS (CHECK ALL THAT APPLY)</b>				
SYMPTOM ONSET DATE	ASYMPTOMATIC	GENITAL ULCER	OCULAR INVOLVEMENT	OTHER (SPECIFY):
START DATE (YYYY-MM-DD):	ANAL ULCERATIVE LESIONS	HAIR LOSS (ALOPECIA)	ORAL ULCERATIVE LESIONS	
	CONDYLOMATA LATA	MENINGITIS	RASH	
<b>SYPHILIS STAGING</b>	PRIMARY	LATE LATENT (GREATER THAN 1 YEAR AFTER INFECTION)	UNKNOWN/UNDETERMINED	
	SECONDARY	TERTIARY	PREVIOUS DIAGNOSIS*	
	EARLY LATENT (LESS THAN 1 YEAR AFTER INFECTION)			
<b>ADDITIONAL PRESENTATIONS (SITES)</b>	NEUROSYPHILIS	GUMMATOUS SYPHILIS	CARDIOVASCULAR SYPHILIS	

\*(IF RECORD OF TREATMENT OUTSIDE MANITOBA PLEASE PROVIDE IN SECTION VII - ADDITIONAL INFORMATION)

**VI. RISK FACTOR INFORMATION (OPTIONAL)**

subject > risk factors

<b>SPECIFY KNOWN APPLICABLE RISK FACTORS IF RELEVANT TO THE PUBLIC HEALTH INVESTIGATION:</b>	<b>ADDITIONAL INFORMATION:</b>
HOUSING UNSTABLE INJECTION DRUG USE HISTORY OF INCARCERATION MEN WHO HAVE SEX WITH MEN PROBABLE ACQUISITION IN ANOTHER COUNTRY OTHER (DESCRIBE OTHER RELEVANT RISK FACTORS OR ADDITIONAL INFORMATION ON ABOVE RISK FACTORS)	

**VII. ADDITIONAL INFORMATION (IF APPLICABLE)**

ADDITIONAL UPDATES TO PREVIOUS INFORMATION SUBMITTED	
<b>FOR LABORATORY CONFIRMED CASES ONLY</b>	
HAS CLIENT/GUARDIAN BEEN INFORMED OF DIAGNOSIS?	YES NO PENDING
(HIV CASE ONLY) HAS NEED FOR HIV DISCLOSURE WITH PARTNERS BEEN DISCUSSED WITH CLIENT/GUARDIAN?	YES NO PENDING
(HIV CASE ONLY) HAS CLIENT BEEN REFERRED TO MANITOBA HIV PROGRAM	YES NO PENDING

**VIII. REPORTER INFORMATION**

FORM COMPLETED BY (PRINT NAME)	FACILITY NAME/ ADDRESS/ PHONE #
FORM COMPLETION DATE (YYYY-MM-DD)	

**REMINDER: TESTING FOR ALL STBBI IS RECOMMENDED**

CLIENT LAST NAME:	CLIENT FIRST NAME:
PHIN:	DOB: (YYYY-MM-DD)



**IX. CONTACTS OF CASE (FOR LAB CONFIRMED CASES ONLY)**

investigation quick entry > exposure summary > create  
transmission event > known contacts  
contact investigation > disposition / intervention

COPY PAGE IF REQUIRED. PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE.

CASE DECLINED TO IDENTIFY CONTACTS	NUMBER OF ANONYMOUS CONTACTS _____		
CONTACT PERSONAL INFORMATION	PREGNANT?	WHO WILL NOTIFY?	EXPOSURE START AND END DATES YYYY-MM-DD
NAME: PHIN (IF KNOWN): DOB/AGE: ADDRESS: PHONE: ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):	YES NO UNKNOWN N/A	PUBLIC HEALTH CASE HEALTH CARE PROVIDER	START DATE      END DATE
NAME: PHIN (IF KNOWN): DOB/AGE: ADDRESS: PHONE: ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):	YES NO UNKNOWN N/A	PUBLIC HEALTH CASE HEALTH CARE PROVIDER	START DATE      END DATE
NAME: PHIN (IF KNOWN): DOB/AGE: ADDRESS: PHONE: ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):	YES NO UNKNOWN N/A	PUBLIC HEALTH CASE HEALTH CARE PROVIDER	START DATE      END DATE
NAME: PHIN (IF KNOWN): DOB/AGE: ADDRESS: PHONE: ALTERNATE CONTACT INFO (E.G PHONE, SOCIAL MEDIA, EMAIL):	YES NO UNKNOWN N/A	PUBLIC HEALTH CASE HEALTH CARE PROVIDER	START DATE      END DATE

PLEASE SUBMIT THIS FORM: MHSU-6781 (2024-09) – PROVIDER REPORT FORM FOR SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS (STBBI) AND STI TREATMENT, BY SECURED FAX OR COURIER TO THE MANITOBA HEALTH SURVEILLANCE UNIT. 4050 – 300 CARLTON ST. WINNIPEG, MB | CONFIDENTIAL FAX 204-948-3044 AFTER HOURS EMERGENCY PHONE FOR PUBLIC HEALTH ISSUES IS (204) 788-8666.

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