* CASE ACCESSION NUMBER OR CASE INVESTIGATION ID ☐ CASE NOT IDENTIFIED	CASE SPECIMEN COLLECTION DATE	TRANSMISSION EVENT ID

STBBI CONTACT INVESTIGATION FORM (FOR CONTACTS TO CHLAMYDIA, GONORRHEA, CHANCROID, LGV, HEPATITIS B/C, HIV, AND SYPHILIS INFECTIONS)

CONTACT FORM

I. *INVESTIGATION INFORMATION

1. CONTACT TO A CASE OF	☐ CHLAMYDIA ☐ GONORRHEA ☐ LGV ☐ CHANCROID ☐ HBV ☐ HCV ☐ HIV ☐ SYPHILIS
2. INVESTIGATION DISPOSITION	○ FOLLOW-UP COMPLETE ○ UNABLE TO COMPLETE INTERVIEW ○ PENDING
3. DOES CASE PLAN TO NOTIFY THIS CONTACT HIM/HERSELF?	☐ YES ☐ NO ☐ NOT ASKED
4. RESPONSIBLE ORGANIZATION	○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC
5. OTHER ORGANIZATIONS INVOLVED	☐ WRHA ☐ NRHA ☐ PMH ☐ SH-SS ☐ IERHA ☐ FNIHB ☐ CSC ☐ DND

II. *CLIENT IDENTIFICATION

subject > client details > personal information

6. LAST NAME	7. FIRST NAME	8. SEX ○ FEMALE ○ MALE ○ INTERSEX ○ UNKNOWN
9. ALTERNATE LAST NAME	10. ALTERNATE FIRST NAME	11. DATE OF BIRTH/APPROX. AGE IF DATE USE YYYY - MM - DD
12. MHSAL REGISTRATION NUMBER 6 DIGITS	13. HEALTH NUMBER (PHIN) 9 DIGITS	14. ALTERNATE ID SPECIFY TYPE OF ID
15. ADDRESS AT TIME OF TESTING ➔ ☐ ADDRESS IN FIRST NATION COMMUNITY		16. CITY/TOWN/VILLAGE
17. PROVINCE/TERRITORY	18. POSTAL CODE A#A #A# / 19. PHONE NUMBER ### - ### - ####	MHSU USE ONLY
20. ALTERNATE ADDRESS/LOCATING INFORMATION		
21. PHYSICAL DESCRIPTION IF UNABLE TO IDENTIFY CLIENT		

COMPLETE SECTIONS III AND IV BASED ON INFORMATION PROVIDED BY THE CASE

III. RISK FACTOR INFORMATION

subject > risk factors

22. **CONTACT KNOWN TO BE PREGNANT?** ○ NO ○ UNKNOWN ○ NOT APPLICABLE ○ YES (COMPLETE SECTION VI EDC FROM CONTACT)

IV. EXPOSURE DETAILS

investigation > exposure summary > maintain transmission event details

23. MODE OF TRANSMISSION (SELECT ALL THAT APPLY)	24. *EXPOSURE START DATE	25. EXPOSURE END DATE
☐ SEXUAL ☐ BLOODBORNE ☐ PERINATAL (IF PERINATAL SKIP TO SECTION V)	YYYY-MM-DD ☐ ESTIMATED	YYYY-MM-DD

A. SEXUAL EXPOSURE

>> transmission event details > transmitter role
>> source details > mode of transmission = sexual contact

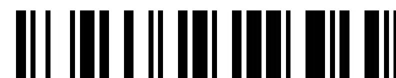
26. SEXUAL RELATIONSHIP (SELECT ONE ONLY)	○ REGULAR PARTNER ○ CASUAL PARTNER ○ HAS GIVEN GOODS IN EXCHANGE FOR SEX ○ HAS RECEIVED GOODS IN EXCHANGE FOR SEX ○ DECLINED TO ANSWER
27. TYPE OF SEXUAL EXPOSURE (SELECT ALL THAT APPLY)	☐ VAGINAL SEX ☐ ANAL SEX ☐ ORAL SEX
28. FREQUENCY OF SEXUAL CONTACT EVENTS	○ ONCE ONLY ○ 2-10 TIMES ○ 11+ TIMES ○ UNKNOWN ○ DECLINED

B. BLOOD AND PERCUTANEOUS EXPOSURES

>> source details > mode of transmission = bloodborne

☐ DRUG PARAPHERNALIA SHARING	☐ BLOOD-MUCOUS MEMBRANES	☐ SHARED TATTOO, BODY PIERCING, SCARIFICATION EQUIPMENT	☐ HOUSEHOLD (HEPATITIS B ONLY) >> exposure location > exposure setting type	☐ OTHER BLOODBORNE EXPOSURES SPECIFY

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.



* CASE ACCESSION NUMBER OR CASE INVESTIGATION ID	TRANSMISSION EVENT ID	CONTACT NAME OR INITIALS	CONTACT PHIN

C. EXPOSURE SETTING LOCATION

>> exposure summary > maintain transmission event details > exposure location

29. **WHERE / HOW DID YOU FIRST MEET THIS CONTACT (SELECT ONE ONLY FOR NEW CONTACTS DURING EXPOSURE PERIOD)**

☐ BATHHOUSE	☐ BAR/CLUB	☐ HOTEL	☐ HOUSE PARTY
☐ FRIENDS/FAMILY	☐ OUTDOORS (PARKS, STREETS, ETC)	☐ CORRECTIONAL FACILITY	☐ SHOPPING MALL
☐ WORK/SCHOOL	☐ OTHER COMMUNITIES IN MANITOBA	☐ OTHER PROVINCE IN CANADA	☐ OUTSIDE CANADA
30. **INTERNET WEBSITES/APPS** ☐ FACEBOOK ☐ GRINDR ☐ OTHER (SPECIFY)	31. **CONTACT'S ONLINE NAME(S)**	32. **LOCATION OF FIRST PHYSICAL MEETING** SPECIFY LOCATION	☐ OTHER SETTING SPECIFY SETTING, NAME, AND LOCATION

V. REPORTER INFORMATION FOR CASE INTERVIEW

33. **FORM COMPLETED BY (PRINT NAME)**	34. **FACILITY NAME/ADDRESS/PHONE #**	**REPORTER USE ONLY**
35. **SIGNATURE**		
36. **FORM COMPLETION DATE** YYYY-MM-DD	37. **ORGANIZATION** (IF APPLICABLE) O WRHA O NRHA O PMH O SH-SS O IERHA O FNIHB O CSC	

COMPLETE THE REST OF THE FORM BASED ON CONTACT FOLLOW-UP

VI. RISK FACTOR INFORMATION

subject > risk factors

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
PREGNANT AT TIME OF INVESTIGATION SPECIFY EDC: YYYY-MM-DD	O	O	O	O	O
HISTORY OF STBBI(S) (IF KNOWN) SPECIFY INFECTION(S) AND DATE(S	O	O	O	O	O

VII. SIGNS AND SYMPTOMS

investigation > signs and symptoms

38. **SIGNS AND SYMPTOMS** O ASYMPTOMATIC O SYMPTOMATIC	39. **EARLIEST SYMPTOMS ONSET DATE** YYYY-MM-DD

VIII. TREATMENT INFORMATION

investigation > prescriptions > prescription summary

40. **PRESCRIBER NAME**	41. **FACILITY NAME**

42. **CONTACT RECEIVED EPIDEMIOLOGICAL TREATMENT DURING THIS EPISODE?** O YES O NO O UNKNOWN

☐ BENZATHINE PENICILLIN G 2.4 million units IM as single dose SPECIFY START DATE: YYYY-MM-DD	☐ BENZATHINE PENICILLIN G 2.4 million units IM weekly for 3 doses SPECIFY START DATE: YYYY-MM-DD

☐ AZITHROMYCIN 1g PO x1 SPECIFY START DATE: YYYY-MM-DD	☐ DOXYCYLINE 100 mg PO BID x7 days SPECIFY START DATE: YYYY-MM-DD	☐ METRONIDAZOLE 500 mg PO BID x14 days SPECIFY START DATE: YYYY-MM-DD
☐ CEFIXIME 800 mg PO x1 SPECIFY START DATE: YYYY-MM-DD	☐ AMOXICILLIN 500 mg PO TID x7 days SPECIFY START DATE: YYYY-MM-DD	☐ OTHER (SPECIFY TREATMENT): SPECIFY START DATE: YYYY-MM-DD
☐ CEFTRIAXONE 250 mg IM x1 SPECIFY START DATE: YYYY-MM-DD	☐ ERYTHROMYCIN 500 mg PO QID x7 days SPECIFY START DATE: YYYY-MM-DD	

43. **ALLERGIES (RELEVANT TO TREATMENT)**

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

* CASE ACCESSION NUMBER OR CASE INVESTIGATION ID	TRANSMISSION EVENT ID	CONTACT NAME OR INITIALS	CONTACT PHIN

IX. EVIDENCE-BASED INTERVENTIONS

>> treatment and interventions > interventions summary

44. RECOMMENDED IMMUNIZATIONS						
	☐ HBV	○ RECOMMENDED	○ ADMINISTERED	○ IMMUNE	○ DECLINED	○ NOT APPLICABLE
	☐ HBIG	○ RECOMMENDED	○ ADMINISTERED	○ IMMUNE	○ DECLINED	○ NOT APPLICABLE
	☐ HAV	○ RECOMMENDED	○ ADMINISTERED	○ IMMUNE	○ DECLINED	○ NOT APPLICABLE

45. STBBI TESTING RECOMMENDED/COMPLETED				46. LOCATION OF TESTING IF KNOWN	47. DATE (YYYY-MM-DD)
☐ CHLAMYDIA	○ POSITIVE	○ NEGATIVE	○ UNKNOWN		
☐ GONORRHEA	○ POSITIVE	○ NEGATIVE	○ UNKNOWN		
☐ HEPATITIS B	○ POSITIVE	○ NEGATIVE	○ UNKNOWN		
☐ HEPATITIS C	○ POSITIVE	○ NEGATIVE	○ UNKNOWN		
☐ HIV	○ POSITIVE	○ NEGATIVE	○ UNKNOWN		
☐ SYPHILIS	○ POSITIVE	○ NEGATIVE	○ UNKNOWN		

48. ☐ **EDUCATION – CONDOM USE**

49. ☐ **OTHER INTERVENTION**

SPECIFY

X. *REPORTER INFORMATION (IF NOT RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE)

50. FORM COMPLETED BY (PRINT NAME)	51. FACILITY NAME/ADDRESS/PHONE#	REPORTER USE ONLY
52. SIGNATURE		
53. FORM COMPLETION DATE YYYY-MM-DD	54. ORGANIZATION (IF APPLICABLE) ○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC	STAMP HERE

XI. *RESPONSIBLE REGIONAL PUBLIC HEALTH AUTHORITY USE ONLY

55. FORM COMPLETED BY (PRINT NAME)	56. SIGNATURE	57. FORM COMPLETION DATE YYYY-MM-DD
58. FORM REVIEWED BY (PRINT NAME)	59. FORM REVIEWED DATE YYYY-MM-DD	RHA USE ONLY
60. INVESTIGATION STATUS ○ ONGOING ○ CLOSED TO THE REGION	61. ORGANIZATION ○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC	STAMP HERE

PLEASE SUBMIT THIS INVESTIGATION FORM BY SECURED FAX OR COURIER TO THE SURVEILLANCE UNIT AT MANITOBA HEALTH
AFTER HOURS EMERGENCY PHONE FOR PUBLIC HEALTH ISSUES: (204) 788-8666

THIS FORM IS ALSO AVAILABLE FOR DOWNLOAD IN A FILLABLE PDF FORMAT AT
http://www.gov.mb.ca/health/publichealth/surveillance/docs/mhsu_6782.pdf

A USER GUIDE FOR COMPLETION OF SURVEILLANCE FORMS FOR REPORTABLE DISEASES AND INSTRUCTIONS FOR THIS FORM ARE AVAILABLE FOR DOWNLOAD AT
http://www.gov.mb.ca/health/publichealth/surveillance/forms.html

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