

CHLAMYDIA TREATMENT CARE PATHWAY

PATIENT DETAILS

Patient Name & Address	Index patient IWCSP
Telephone No:	Contact IWCSP
Index Patient IWCSP No:	If Contact, Index Px IWCSP NO
Date of birth (day/month/year)	<input type="radio"/> Male <input type="radio"/> Female
Place of attendance Date of attendance	

MEDICAL HISTORY

DETAILS

Past Medical History	Yes		No					
Previous STI	Yes		No					
Medications	Yes		No					
Allergies	Yes		No					
LMP		Contraception		LSI				
Risk of Pregnancy?	Yes		No		Breast - feeding?	Yes		No

Treatment and advice

Treatment given: <input type="checkbox"/> Doxycycline 100mgs bd x 7 days <input type="checkbox"/> Azithromycin 1 gram stat <input type="checkbox"/> Erythromycin 500mgs bd x 14 days Batch number: Expiry date: Advice given:	<input type="checkbox"/> How to take medication <input type="checkbox"/> Side effects (PGD) <input type="checkbox"/> Sexual health advice and condoms offered <input type="checkbox"/> Informed of Sexual Health Services
Authorising Healthcare Professional signature	

CONTACT(S) INFORMATION

<u>1. NAME</u>			
DOB			
PHONE NO.			
ADDRESS		☐ Contact card given	
<input type="checkbox"/> Already screened within last month <input type="checkbox"/> To attend Sexual Health Service		<input type="checkbox"/> Patient to contact <input type="checkbox"/> CSP to contact	
Date 1 st Contact Date 2 nd Contact Date 3 rd Contact <input type="checkbox"/> Letter <input type="checkbox"/> Letter <input type="checkbox"/> Letter <input type="checkbox"/> Text <input type="checkbox"/> Text <input type="checkbox"/> Text		<input type="checkbox"/> Phone <input type="checkbox"/> Phone <input type="checkbox"/> Phone	
Notes:			
<u>2. NAME</u>		DOB	PHONE NO.
ADDRESS		☐ Contact card given	
<input type="checkbox"/> Already screened within last month <input type="checkbox"/> To attend Sexual Health Service		<input type="checkbox"/> Patient to contact <input type="checkbox"/> CSP to contact	
Date 1 st Contact Date 2 nd Contact Date 3 rd Contact <input type="checkbox"/> Letter <input type="checkbox"/> Letter <input type="checkbox"/> Letter <input type="checkbox"/> Text <input type="checkbox"/> Text <input type="checkbox"/> Text		<input type="checkbox"/> Phone <input type="checkbox"/> Phone <input type="checkbox"/> Phone	

Notes:

3. NAME

DOB
PHONE NO.

ADDRESS

Contact card given

Already screened
within last month

Patient to contact
 CSP to contact

To attend Sexual Health
Service

Date 1st Contact
Date 2nd Contact
Date 3rd Contact

Phone
 Phone
 Phone

Letter
 Letter
 Letter
 Text
 Text
 Text

Notes:

Name: _____

Signature: _____