Confidential STD PATIENT FORM - REGISTRATION

National STD/AIDS Control Programme, Central STD Clinic, Colombo 10

Patient Registration Number: | | | | | | | |

Date of registration: | | | | | | (dd/mm/yy)

Drug Sensitivity / Allergy	

First name/Initials: …..…… Last name: ……..

Current address: ……... Phone: ……

…..…… Phone: ……

…….. Phone: ……..

Permanent address: …….. Phone: ……..

……..…… Phone: ……..

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Sex	1. Male 2. Female	
Date of birth (dd/mm/yy)		| | | | | |
Marital status	1. Single/Never married 2. Married/ Living together 3. W/S/D	
Nationality	1. Sri Lankan 2. Others ……	

Preferred mode of contact	1. Do not contact	2. Letter	3. Email	4. T. phone	5. Visit				

(If contact details are changed during subsequent visits, update new details below)

Contact address: …… Phone: ……..……..

Contact address: …… Phone: ……

E-mail address: …… Phone: ……..

E-mail address: …… Phone: ……..

(Use the space below if there are comments that are important and relevant to future clinic visits)

Date	**Comment**

MALE PATIENT FORM - EPISODE OF CARE

Patient file number: | | | | | | | |

Episode Number: | | | |

Seen By (Name/Designation): . . ……………………………………………
Time In: ………………………… ……. Time Dr: …………………………
Age of the Patient: …. …………………

1. Date of visit (dd/mm/yy)		
2. Highest level of education	1. 1-5 grade 2. 6-10 grade 3. G.C.E O/L 4. G.C.E A/L 5. Dip/ Degree 6. No schooling/NA 2	
3. Occupation (12 months)	1. UE 2. Student 3. CSW 4. Retired 5. Employed as 3	
4. Reason for attendance	1. Voluntary 2. Ref. OPD 3. Ref. Ward 4. Ref. GP 5. Ref. Courts 6. Ref. Blood bank 7. Contact 8. Clinic follow up 9. Medico-legal 10. Other Ref. no………….. ………………… …..……………… 4	
5. Symptoms	1. None 2. Genital disch. 2. Dysuria 4. Warts 5. Genital ulcer 6. Rash 7. Scrotal swelling 9. Others 5	
6. Duration of symptom/s(days)	1. NA 2. 1-3 3. 4-7 4. 8 – 14 5. Over 14 6. Unknown 6	
7. Medication (14 days)	1. None 2.Antibiotics 3.Others/NK 7	
13. Sex contacts (12 months)	1. None/NA 2. Sri Lankan 3. Foreign 4. (2&3) 13	
14. Type of partner (12 months)	1. None/NA 2. Marital/Regular Partner 3. Non-regular P 4. Commercial Partner/Client 14	
15. Sex of Partner/s (12 months)	1. Male only 2. Male & Female 3. Female only 4. None/NA 15	
16. Number of partners(3 months)	1. One 2. Two 3. Three 4. Four 5. Five or more 6. None/NA 16	
17. Condoms use at last sex	1. NA 2. No 3. Yes 17	
18. Condoms use in last 3 months	1. NA 2. Never 3. Sometimes 4. Always 18	
19. Substance abuse (12 months)	1. None/NA 2. Narcotics (Inhalation/oral) 3. Alcohol 4. IDU 19	
20. Previous STD	1. None 2. GC 3. Syphilis 4. Herpes 5. Chlamydia/NGU 6. Warts 7. Others/Not Sure 20	
21. Blood risk (12 months)	1. None 2. Blood/blood product 3. Needle prick 4. Other 21	
22. Ever had an HIV test	1. Never 2. Negative 3. Positive 4. Indeterminate 5. Tested but result not sure 6. Don't know 22	
23. Age at first sex (in years) (Write 99 if not applicable /not known) 23		

Regular partner *- refers to marital partner or cohabiting (live-in) partner.*
Non-regular partner *- refers to casual or non-cohabiting partner /girl or boy friend.*
Commercial partner/Client *- refers to sex worker* ***or*** *client of sex worker*

SUMMARY OF SEXUAL HISTORY

	When / Whom	Type of sex	Condom Y / N	SL / Overseas
LSI				
PSI				
PSI				

History:

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	Male	Female
Total number of partners last 3 months		
Total number of partners last 1 year		
Total number of partners life time		

MALE PATIENT FORM - EPISODE OF CARE

Patient file number: | | | | | | | | Episode number: | | |

EXAMINATION

24. Signs	1. None 2. Gen. discharge 3. Inguinal LN 4. Genital warts 5. Genital Ulcer 6. Rash 8. Scrotal swelling 9. Others 10. Not Exam 24		
25. Circumcision	1. No 2. Yes 25		

INVESTIGATION

26. FPU Deposit *(x1000)*	1. Not done/NA 2. Pus cells < 10 3. Pus cells ≥10 4. Other……. 26		
27. Dark Ground for TP	1. Not done 2. Negative 3. Positive 27		
28. Giant Cells	1. Not done 2. Negative 3. Positive 28		
29. Urethral smear *(x1000)*	1. Not done 2. ICGND 3. <5 Pus cells/NAD 4. 5-9 Pus cells 5. ≥ 10 Pus cells 6. Other 29		
30. Urethral GC culture	1. Not done 2. Negative 3. Positive 4. Report NA 30		
31. Urethral Chlamydia	1. Not done 2. Negative 3. Positive 4. Indeterminate 5. Report NA 31		
37. Throat GC culture	1. Not done 2. Negative 3. GC 4. Others 5. Report NA 37		
38. Rectal GC culture	1. Not done 2. Negative 3. GC 4. Report NA 38		
39. HSV Ag ELISA	1. Not done 2. Negative 3. Positive 4. Report NA 39		
40. HSV culture	1. Not done 2. Negative 3. Positive 4. Contaminated 5. Report NA (Type 1, Type 2) 40		
41. HSV Serology	1. Not done 2. Negative 3. Positive 4. Report NA Type 1 - lgM, lgG Type 2 - lgM, lgG 41		
42. VDRL	1. Not done 2. Non reactive 3. Prev. reactive (treated) 4. Reactive 5. Report NA Titre ……..... 42 Titre …….....		
43. TPPA/TPHA	1. Not done 2. Non reactive 3. Prev. reactive(treated) 4. Reactive 5. Equivocal 6. Report NA 43		
44. HIV Screening test	1. Not done 2. Negative 3. Prev. positive 4. Positive 5. Inconclusive 6. Report NA 44		
45. HIV Confirm. test	1. Not done 2. Negative 3. Known positive 4. Positive 5. Inconclusive 6. Report NA 45		
46. Hep B SAg	1. Not done 2. Negative 3. Prev. positive 4. Positive 5. Report NA 46		
47. Hep C Ab	1. Not done 2. Negative 3. Prev. positive 4. Positive 5. Report NA 47		

Other tests:

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Management / Treatment:

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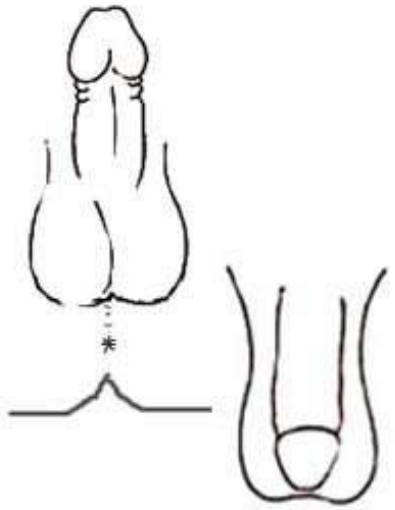
L.P.U ……. Hrs ago



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Assessment / provisional diagnosis:

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Note: *Send the patient for an interview (FI)/partner notification in case of* ***GC, Syphilis, Chlamydia, NGU or Trichomoniasis.***

Follow up 1. None /Optional 2. Yes 3. Referral 4. Other

Date and reason for follow up:..……....
……
Notes checked by (SMO 1): ……...……...…

MALE PATIENT FORM - EPISODE OF CARE

Episode number: | | | |

1st Follow up visit	**DATE** *(dd/mm/yy):*……..	Time in :……	Time Dr :……..

Seen by (Name and Designation)_____

Follow up 1. Yes (Date/Reason) ……. 2. None/Optional 3. Referred 4. Other…….……...

2nd Follow up visit	**DATE***(dd/mm/yy):* ……..	Time in :……	Time Dr: ……..

Seen by (Name and Designation)_____

Follow up 1. Yes (Date/Reason) …… 2. None/Optional 3. Referred 4. Other……

3rd Follow up visit	**DATE***(dd/mm/yy)*: ……..	Time in: ……	Time Dr: ……..

Seen by (Name and Designation)_____

Follow up 1. Yes (Date/Reason) …… 2. None/Optional 3. Referred 4. Other……

MALE PATIENT FORM - EPISODE OF CARE

Episode number ☐☐☐

4th Follow up visit	**DATE***(dd/mm/yy)***:……..**	Time in: ……	Time Dr: ….……..

Seen by (Name and Designation)_____

Follow up 1. Yes (Date/Reason) …… 2. None/Optional 3. Referred 4. Other……..……

5th Follow up visit.	**DATE***(dd/mm/yy)***: ……**	Time in: ……	Time Dr:. ……..

Seen by (Name and Designation)_____

Follow up 1. Yes (Date/Reason) …… 2. None/Optional 3. Referred 4. Other……..……

COMPLETION OF EPISODE OF CARE

48. Etiological diagnosis of current episode of care	1. No illness 4. Early syphilis 7. Genital herpes 10. Trichomoniasis 13. Scabies 17. Molluscum 20. Non STD illness	2. HIV positive 5. Late syphilis 8. Chlamydia 11. Warts 14. Candida 18. Opth. neonatorum 21. Uncertain	3. GC 6. Congenital syphilis 9. NGU/NGC 12. Pubic lice 16. Epididymitis 19. Other STD 22. '*Continuation of the previous episode'* 48	☐	☐
49. Syndrome	1. NA 4. Opth. Neonatorum 9. Other	2. GUD – non vesicular 7. Urethral discharge	3. GUD - vesicular 8. Scrotal swelling 49	☐	☐
50. Treatment	1. None 4. Cryotherapy 7. Metranidazole 10.Cephalosporins 13. Aciclovir	2. Penicillin 5. Podophyllin 8. Scabicides 11. Quinolones 14. Cotrimoxazole	3. Doxycycline 6. TCA - Trichloroacetic acid 9. Macrolides 12. Antifungals 15. Others …… 50	☐	☐

51. Status of the episode	1. Completed 2. Referred 3. Defaulted 4. Episode to be continued 5. Other 51	☐
52. No of visits	1. One 2. Two 3. Three 4. Four 5. Five 6. Six 52	☐
Final check by (SMO 2)		
Date (*dd/mm/yy)*		

Note: *If contacts are away from the area, send H 18 forms to relevant STD clinic.*

1. Send to …… 2. Not send /NA

PARTNER STATUS

A. Regular partner (Marital /Cohabiting)

Contact slip No (given by PHI): ……..……

Attended Clinic: 1. Yes 2. No 3. NA

Clinic number : ……..

Diagnosis : ……....

Treatment given : ……

B. Non-regular partners/Commercial partners/Clients

Contact slips No (given by PHI) :……..……

Clinic number/s :……..……...

Diagnoses : ……..

Treatments given : ……