User Manual for STI Patient Information Management System (PIMS)

2008 June

National STD/AIDS Control Programme, Ministry of Health, Sri Lanka.

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FOREWORD

The goal of the National STD/AIDS Control Programme is to maintain the current low prevalence of HIV infection in the country. Two core strategic objectives identified in the National Strategic Plan (2007-2011) are increased coverage and effectiveness of prevention interventions and increased coverage and effectiveness of care, support and treatment interventions. Increased quality and coverage of STI services is one important strategy which would enable to reduce the incidence of HIV infection as epidemiological studies have proven that the presence of sexually transmitted infections (STI) facilitate the spread of HIV infection. STI services are provided by the Central STD clinic and a network of peripheral clinics. The Central STD clinic of the national programme has also to coordinate, guide, monitor and facilitate the activities of provincial STD services.

With the establishment of the strategic Information Management System it became necessary to develop a patient management information system (PIMS). After careful planning PIMS was designed to gather data from patients and the services offered in a systematic manner using standard pre tested formats and guidelines which provide definitions and instructions for data collection and interpretation so that data triangulated from sources such as laboratory and pharmacy would provide the total landscape of patient management. The system would also capture data of people living with HIV who will be utilizing clinic services. Their epidemiological, clinical, immunological data and information on provision of antiretroviral therapy will be collected. The results could be then compared across reporting sites, geographical locations or time. Quarterly and annual reports should be disseminated for utilization of stakeholders. Using these evidence based information strategies could be continued or modified to improve the quality of care.

I take this opportunity to acknowledge the contribution made by Consultant Venereologists and other senior medical staff of NSACP in making this endeavour a success. Funding for the project was provided by the National HIV/AIDS Prevention Project funded by World Bank. Last but not least my appreciation should go to the software development team of Price Waterhouse Coopers Ltd. Finally I am confident that this system would provide valuable inputs to achieve the goal of the NSACP.

Dr N. Edirisinghe
Director
National STD/AIDS Control Programme

ABBREVIATIONS AND ACRONYMS

AGA	Atypical Glandular Cells
ASCUS	Atypical Squamous cells of Undetermined Significance
BEC	Benign Endometrial Cells
CSF	Cerebrospinal Fluid
CSW	Commercial Sex Worker
DMPA	Depot Medroxyprogesterone Acetate
ELISA	Enzyme Linked Immunosorbent Assay
EMS	Early Morning Sample
FI	For Interview
FPU	First Pass Urine
GC	Gonococci
GP	General Practitioner
HBs Ag	Hepatitis B surface antigen
HIV	Human Immunodeficiency Virus
HSIL	High-grade Squamous Intraepithelial Lesion
HSV	Herpes Simplex Virus
HSV Ag	Herpes Simplex Virus Antigen
ICGND	Intra-cellular Gram Negative Diplococci
IUCD	Intra Uterine Contraceptive Devices
JMO	Judicial Medical Officer
LMP	Last Menstrual Period
LN	Lymphnodes
LPU	Last Pass Urine
LRT	Ligation and Resection of Tubes
LSI	Last Sexual Intercourse
LSIL	Low- grade Squamous Intraepithelial Lesion
NA	Not Applicable
NAD	No Abnormality Detected
NGC	Non-Gonococcal Cervicitis
NGU	Non-Gonococcal Urethritis
NILM	Negative for Intraepithelial Lesion or Malignancy
NK	Not known
NSACP	National STD/AIDS Control Programme
OPD	Out Patient Department
PHI	Public Health Inspector
PHNS	Public Health Nursing Sister
PID	Pelvic Inflammatory Disease
PMNL	Polymorphonuclear Leucocytes
PSI	Previous Sexual Intercourse
SGM	Squamous or Glandular Malignancy
SMO 1	Senior Medical Officer 1
SMO 2	Senior Medical Officer 2
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TOC	Test Of Cure
TPHA	Treponema Pallidum Haem Agglutination
TPPA	Treponema Pallidum Partical Agglutination
TV	Trichomoniasis
UE	Unemployed
VDRL	Venereal Disease Research Laboratory
W/D/S	Widowed/Divorced/Separated

CONTENTS

INTRODUCTION

National STD/AIDS Control Programme (NSACP) has developed a computerized Patient Management Information System (PIMS) for STI services. This will enhance the efficiency of clinic procedures, enable to note of changing disease pattern and track trends in STIs and provide a valuable database for monitoring, evaluation and research purposes.

Formats for male and female patient management have been newly developed in order to facilitate computer data entry. These forms enable clinic staff to interpret the data in a standardized manner so that data are comparable.

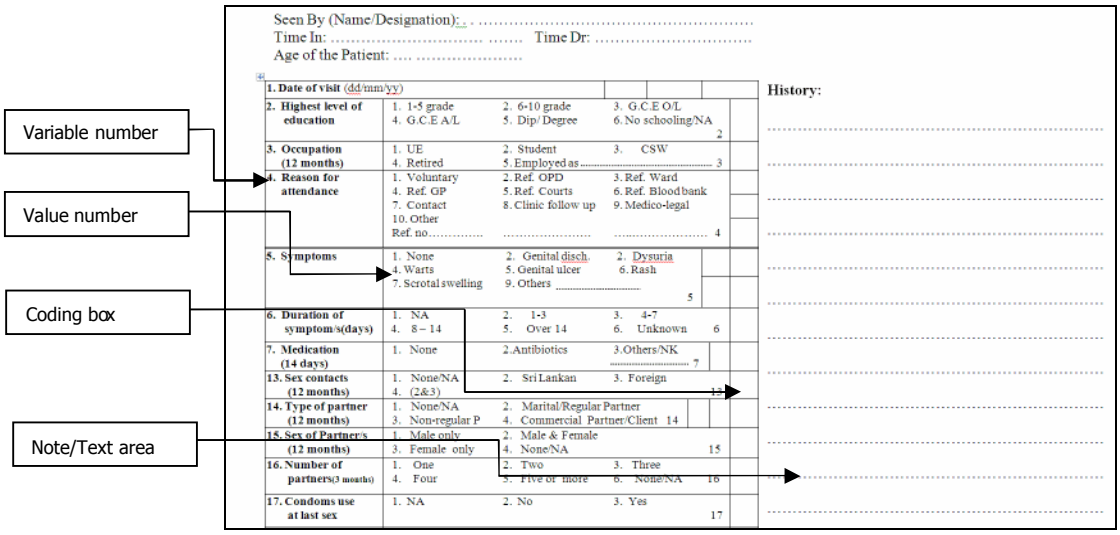
The purpose of this brief manual is to introduce the new computerized patient management system and to provide guidelines on the completion of patient management forms. It is important to study this manual thoroughly until the user becomes familiar with the guidelines.

The instructions given in this manual are primarily to enhance the quality of information gained from a STD patient. It should be noted that, this is an important and integral part of the proper patient management. For clinical management purposes, appropriate clinical guidelines should be referred.

How to use this manual

This manual has been prepared to guide users of Patient Information Management System (PIMS). Instructions and definitions of variables in this manual are given according to the sequence of variables appear in the patient forms. Therefore, users are advised to refer the manual along with the male and female forms.

It is important to understand the following terms, as they appear repeatedly in the manual.



INSTRUCTIONS FOR MAINTAINING STI PATIENT INFORMATION MANAGEMENT SYSTEM

This computerized Patient Information Management System has 5 main steps.

1. Registration by the staff at reception (PHNS and PHI sections).
2. Completion of patient form during consultation.
3. Coding of the variables and filling gaps (Refer the duties of SMO 1 in page 16).
4. Completion of the episode of care and finalizing the diagnoses. (Refer the duties of SMO 2 in page 20).
5. Computer data management (Data entry, data cleaning, analysis and report generation).

1. USE OF PATIENT FORM BY THE RECEPTION STAFF

The reception staff (PHI/PHNS) should decide whether the patient is new or has attended the clinic before (1st visit or subsequent visits).

i. New patients (Patients who have attended the clinic for the first time)

A new patient form is opened with a 'patient registration number' (formally Master number) and the reception staff (PHI/PHNS) will complete the appropriate details on 1st page (except the drug sensitivity box and comments table) and up to the fourth variable in the 2nd page of the patient form. A card containing the patient registration number is given to the patient.

The above data should be entered into the computer placed at the reception, ideally at the same time or at least on the same day. The Patient registration number that is assigned to a patient remains unchanged for all future visits. The patient will be identified by this number.

Format of the Patient registration number (Master number)

M / xxxx / xx - for males, F/ xxxx / xx - for females

First four digits start ***from 1 at the beginning of each yea****r separately for males and females.*

Last 2 digits indicate year of registration e.g. 2008 given as 08

e.g. M/0001/08 will be assigned to the first new male patient who was registered on 1st of January 2008

ii Patients on subsequent visits (Patients who are already registered in the clinic)

If the patient has been to the clinic before, check whether the patient has a clinic registration number. If so, retrieve the patient's file. If not, patient is interviewed by PHI/PHNS for necessary

data and an attempt will be made to trace the previous clinic number using the search facility of the computer system. Where necessary, the patient's contact details should be updated (e.g. address, telephone number).

Then it is necessary to decide whether the patient's present clinic attendance is a continuation of the last "episode of care" or whether in fact it is to be considered as a new "episode of care" (see below). If it is the same episode of care, the receptionist will fill the "date" and "time in" sections in the appropriate follow up visit box given on page 4 or page 5 of the patient form. Then the patient form is ready for clinic consultation.

If the patient has come for a new 'episode of care', an episode of care form is annexed to the existing patient form (page 2-5 of the form). Reception staff should fill relevant details and send for clinic consultation.

Important: After the patient is seen by the consulting doctor, all patient forms should be returned to the reception to enter the follow up date given by the doctor into the computer system (PIMS).

This will enable the reception staff (using the computer system),

1. To select patients who should arrive on a particular date
2. To select defaulted patients on a particular date (or for a period)

Episode of care

Episode of care is a new concept that is being introduced with the computerized Patient Information Management system.

An episode of care refers to a collection of clinic attendances that arise from;

1. Management of patient's initial reason for clinic attendance,

and also

2. Management requirements resulting from investigations conducted at the initial visit.

It should not be confused with the term 'STI episode' which refers to a 'STI diagnosis. In a given "episode of care" a patient can have up to six clinic visits and multiple "STI diagnoses".

Indications to add an episode of care form

New patients: All newly registered patients need the new episode care form (page 2-5) attached to the registration form (page 1) for clinic consultation process.

Patients on subsequent visits: For these patients, it is necessary to decide whether to add an episode of care form again or to continue the existing form.

Indications for adding an episode of care form to the existing patient record.

1. **Completed forms:** The previous episode of care has been completed as indicated by marking the follow up value of the previous visit as (a) None/optional or (b) referred. (Note: coding by SMO2 or data entry may or may not have done).

2. **Returned ≥ 3 months later**: The patient has returned more than 3 months later from the previous date of visit. (Due to defaulting or the appointment has been given after 3 months by the doctor).

3. **'New conditions-New episode':** The patient develops another symptom, sign or positive investigation while in a particular episode of care with or without a fresh exposure. e.g. a patient coming on a follow up visits for treatment of genital warts may develop urethral discharge, follow up serology becomes positive etc.

4. **Check up for Sex workers:** It is recommended to add a new episode care form for sex workers who come for checkups as this will provide adequate space in the form for full examination and investigations.

Note: If a repeat test is required as a part of the same episode of care e.g. EMS for NGU, Test of cure for GC, TV, and monthly VDRL as a part of follow up, same episode of care form could be continued. However, if a test becomes newly positive, the existing episode of care should be completed and a new episode of care has to be commenced (A new form should be attached and all relevant variables/values should be circled).

Indications for completion of an episode of care

1. **Follow up care completed:** Further follow up is not necessary/optional or referred to another health facility.
2. **All spaces for follow up visits used:** Patient has attended for more than 5 follow up visits e.g. ongoing treatment for warts
3. **Next appointment ≥ 3 months later**: The appointment is given for follow up visits (e.g. serological tests for Syphilis or HIV, Pap smear) for which the time gap is 3 months or more from the last follow up date.
4. **Defaulted ≥ 3 months:** The patient has defaulted more than 3 months from the date of last appointment.

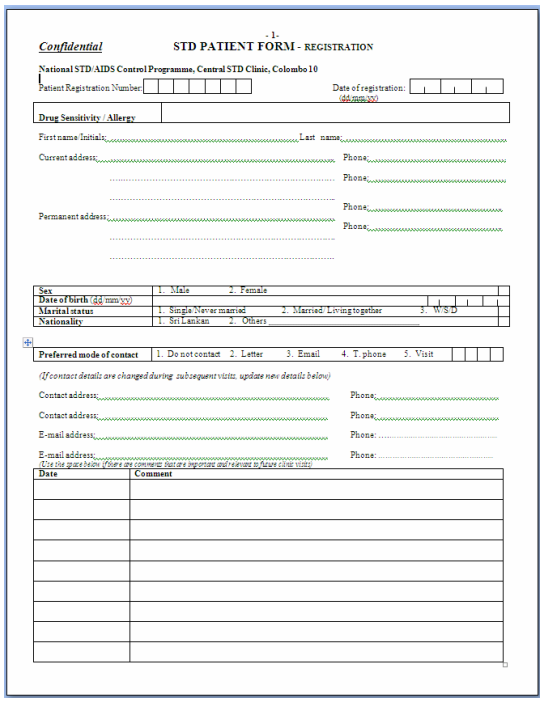
Note: If a repeat test is required as a part of the same episode of care e.g. EMS for NGU, Test of cure for GC, TV, monthly VDRL, same episode of care form could be continued. However, if a test becomes newly positive, the existing episode of care should be completed and a new episode of care has to be commenced (A new form should be attached and all relevant variables/values should be circled)

2. USE OF STD PATIENT FORM BY THE CONSULTING DOCTOR

Although the patient form is designed in a very structured manner for computer data entry, the consulting doctor should take an adequate history in an appropriate history taking style and cover the listed items in the patient form.

A brief guide is given below to complete patient form during the clinic consultation.

STD PATIENT FORM - REGISTRATION (PAGE 1)



- 1 -

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:

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

The 'STD patient form-registration' is common form that is used for both male and female patients. This page contains information that is common to all future episodes of care. However, some details such as contact address may need to be updated on subsequent clinic visits (remember those changes should be updated in the computer data entry window for registration as well)

Following details to be filled by the reception staff (PHI/ PHNS)

- Patient registration number and the episode number in pages 1-5.
- Date of registration
- Name (First name/Initials and Last name)
- Address and contact details
- Sex, Date of birth, marital status and nationality
- Preferred mode of contact and contact details
- Date of visit
- Highest level of education
- Occupation
- Reason for attendance

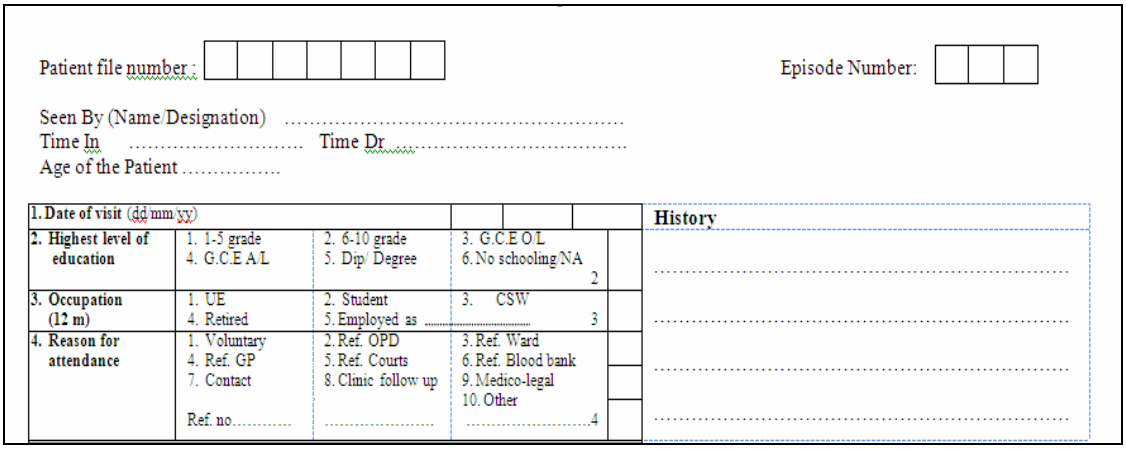
Following details to be filled by the doctor during consultation.

- Drug allergy
- Date and "Comment section" at the bottom of the 1st page

The "comment section" is to be filled only if necessary. Any important reminder for a follow up visit can be written in this space, e.g. significant medical or surgical conditions, a reminder for a Pap smear in case of a female. Routine follow up reasons should not be written here as this space is common to all future episodes of care (Routine follow up reasons should be written in the space provided in page 3 or under each follow up visit).

Male/Female PATIENT FORM – EPISODE OF CARE (PAGE 2)

The following details on page 2 are filled at the reception (except 'Doctors name' and 'Time Dr' which are to be filled by the consulting doctor).



Patient file number : ☐☐☐☐☐☐☐ Episode Number: ☐☐☐

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

					History
1. Date of visit (dd/mm/yy)					
2. Highest level of education	1. 1-5 grade 4. G.C.E A/L	2. 6-10 grade 5. Dip/ Degree	3. G.C.E O/L 6. No schooling/NA	2	
3. Occupation (12 m)	1. UE 4. Retired	2. Student 5. Employed as	3. CSW	3	
4. Reason for attendance	1. Voluntary 4. Ref. GP 7. Contact Ref. no.....	2. Ref. OPD 5. Ref. Courts 8. Clinic follow up	3. Ref. Ward 6. Ref. Blood bank 9. Medico-legal 10. Other 4		

Instructions to complete the above area in the page 2

Patient registration number	This is the unique number given at registration
Episode number	This refers to the number allocated to the episodes of care.
Seen by	Name and designation of the doctor consulting the patient
Time In	The time patient attended the reception(to be filled at reception)
Time Dr	The time patient is consulted (to be filled by the consulting doctor)
Age of the patient	In years as at last birth day

1	Date of Visit	Six digits as dd/mm/yy
2	Highest level of education	1-4. Number of years completed in school 5. Diploma/Degree 6. No schooling/Not applicable (NA)- No school education or children <5 yrs
3	Occupation	1. Unemployed (UE). Not employed currently. 2. Student – whether in a school or other teaching institute 3. CSW – working as a sex worker during last one year 4. Retired - refers to a pensioner who is not employed currently 5. Employed as - If employed, indicate job position e.g. clerk, teacher

4	Reasons for Attendance	1. Voluntary - Patient has attended on his/her own. (Without a referral). 2. Ref. OPD – referral from OPD of any hospital 3. Ref. Ward – referral from a ward of any hospital (army, prison hospitals included) 4. Ref. GP – referral from a general practitioner 5. Ref. courts – referral from the court 6. Ref. Blood bank – e.g. VDRL positive donors 7. Ref. Medico-legal – JMO referrals and any other referrals for medico-legal purposes e.g. alleged victims of sexual assault 8. Contact - If patient came as a result of contact tracing, write the contact slip number in the space provided 9. Clinic follow up- requirement for clinic follow up such as completion of the previous episode of care e.g. treatment for warts, follow up VDRL testing 10. Other – if any other reasons for attendance not included above. 2, 3, 4, 5, 6 & 7 – usually come with a referral note. If there is a referral number, write it in the space provided. Note: A referral note is not essential to classify as referred.

The following details to be filled by the doctor.

Note section for history (Right column)

Doctors are expected to write the relevant details in the history that is not adequately covered by the coded information given on the left side of the page

The patient's history should be taken in the usual manner bearing in mind the information required in cages 5 to 23. It is not considered appropriate to fill up cages 5 to 23 in the manner of completing a questionnaire. The information required should be obtained during history taking and the appropriate value number should be **circled**.

Coding or filling the boxes in the right hand side of each variable(coding box) should not be completed by the doctor who is taking the history or SMO 1. This should be done by another doctor assigned to SMO 2 duties after completion of the episode of care. This will ensure the completeness and accuracy of data (validity of data).

5	Symptoms	**Multiple answers are possible** 1. None - if no symptoms e.g. Patients who come for check ups 2. Genital discharge – Urethral discharge in males *(in females vaginal discharge)* 3. 4, 5 & 7 – self explanatory 6. Rash - if any skin rash in genital or other parts of the body 8. Pelvic pain - Relevant to **females only** 9. Other - Any symptoms without a specific code are classified as other e.g. itching, vaginal odour
6	Duration of symptoms (days)	1. NA - Circle not applicable in the case of patients who have no symptoms. 2, 3, 4 & 5 Self explanatory 6. Unknown or uncertain

7	Medications (taken during last 14 days)	**Multiple answers are possible** Indicate medication taken during last two weeks. 1. None - No medication during last 2 weeks 2. Antibiotics - include oral and topical creams. Write details in the section reserved for history taking. 3. Others/NK – Other agents e.g. Antiviral drugs or when the medications are not known
8	Contraception *(Appear only in female form)*	Refers to current contraception use 1. None/NA - No contraception currently or not applicable e.g. pre-menarche, post menopausal etc 2. IUCD - Intra Uterine Contraceptive Device 3. Oral - Oral pill 4. Condom - Male condoms by the partner 5. Tubal ligation - Surgical (LRT/Vasectomy) 6. Injection – DMPA 7. Natural - Safe period, Coitus interruptus 8. Other - Any other
9	Menstrual cycle *(Appear only in female form)*	1-2. Indicate whether the cycle has been regular or irregular. 3. N/A e.g. pre-menarche, post menopausal, undergone total hysterectomy In the same cage enter the date of the last menstruation, and also the duration in days
10	Pregnant *(Appear only in female form)*	Refers whether the patient is currently pregnant or not.
11	Miscarriage /still birth *(Appear only in female form)*	Refers to history of miscarriage or still birth. Write the Gravidity (G), pregnancies (P) and number of living children (C) in the space given as G P C
12	Termination of pregnancy during last 12 months *(Appear only in female form)*	Refers whether there is a history of termination/s of pregnancy
13	Sexual contacts (12 months)	This refers whether the patient had local or foreign sexual contacts in the last 12 months 1. None/NA - If patient denies having sex with a partner during last 12 months or for children when it is not applicable 2. Only local sexual contacts (regular, non regular or commercial) 3 Only foreign sexual contacts 4. Both local and foreign sexual contacts
14	Type of partner (12month)	**Multiple answers are possible** 1. None/NA - Patient denies having sex during last 12 month or when it is not applicable (e.g. children) 2. Marital P/ Regular P – marital partner or co-habiting partner (live-in) 3. Non regular partner- boy friend, girl friend or casual partner with whom money is not involved. 4. Commercial partner/ Client of sex worker - Money/material involved to have sex (None paying partners of sex workers should be categorized as either regular or non regular)

15	Sex of partners (12months)	Indicate sex of the partner with whom patient had sex during last 12 months. 1. Male only - Had only male partners during last 12 months 2. Male and Female- Had both male and female partners during last 12 months 3. Female only - Had only female partners during last 12 months 4. None/NA - Denies having sex during last 12 months or when it is not applicable (e.g. Neonates or infants)
16	Number of partners (last 3 months)	1-5. Indicate the number of different partners with whom patient had vaginal, anal or oral sex during last 12 month. 6. None/NA – when there are no partners or when number of partners are not applicable (e.g. Neonates, Infants)
17	Condom use at last sex	Refers to male condoms. For females indicate the condom use by male partner 1. NA – When it is not relevant (e.g. never had sex before) 2. No – condom not used in the last sex 3. Yes – condom used in the last sex
18	Condom use last 3 months	Refers to male condoms. For females indicate the condom use by male partner 1. N/A – not relevant (e.g. no sex during last 3 months) 2. Never – Not used condoms during sex in the last 3 months 3. Sometimes- Used condoms inconsistently 4. Always- consistent condom use during last 3 months (disregard condom breakages)
19	Substance abuse (during last 12 months)	1. None/NA (Not used or not relevant e.g. infants) 2. Narcotic drugs taken by inhalation or orally e.g. heroin, cannabis, LSD etc 3. Alcohol 4. IDU - IDU refers to Injecting Drug Use of hard drugs such as Heroin
20	Previous STD	**Multiple answers are possible** 1. Denies ever having a STI 2-6. Relevant STI diagnoses 7. Others/Not sure - Non-listed STIs or if the patient cannot be specific or giving an uncertain history of STIs.
21	Blood risk (during last 12 months)	**Multiple answers are possible** 1. None –denies any exposures to blood or blood products. 2. Presence of exposure to blood or blood products 3. Gives a history of needle prick in healthcare settings 4. Other – (exposure to other potentially infectious materials)
22	Ever had an HIV antibody test	Indicates details of HIV testing 1. Never - Never had a test 2. Negative - Has had a test and result was negative 3. Positive – refers to HIV screening test (HIV confirmatory test positive or awaiting confirmatory test) 4. Indeterminate - Tested and result was indeterminate 5. Tested but results not sure - Tested and patient unaware of the result 6. Patient not aware of testing for HIV
23	Age at first sex (Coitarche)	Write age in years in which patient had penetrative sex (vaginal or anal) for the first time. (Disregard oral or non penetrative sex) Write 99 in the space allocated if not applicable e.g. those who never had sex

Details requested on table given below are to summarize patient's sexual behaviour. However, this section is not meant for computer data entry and complete only if relevant.

SUMMARY OF SEXUAL HISTORY

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

L.S.I. Should be interpreted as Last Sexual Intercourse.
P.S.I. Should be interpreted as Previous Sexual Intercourses.

Describe when it took place and with whom. Type of sex- whether it was vaginal, oral, anal or non-penetrative also writes whether the exposure was with a local or foreign partner.

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

Total number of partners past 3 months, past 1 year, and life time - Record the total number of partners for each period according to the sex of the partner in the appropriate cage.

Male/Female PATIENT FORM – EPISODE OF CARE (PAGE 3)

Patient registration number and episode number to be carried over from previous page. It is necessary to make sure that the space for patient registration number and episode number has been completed by the reception staff.

EXAMINATION

Use the diagram of genitals provided to illustrate the lesions. (e.g. ulcers and warts)
Details of general examination and signs in genital areas should be described in the note-section provided below the diagram.

24	Signs	**Multiple answers are possible** Signs listed in Item 24 refers to examination findings in the anogenital area. Any other findings from the general examination should be written as a note in the section on the right side of the form. 1. None – Genital examination done and no signs found 2. Genital discharge - refers to urethral discharge in males and vaginal or cervical discharge in females 3. Inguinal LN – enlarged inguinal lymph nodes 4. Genital warts – Warty lesions clinically suggestive of HPV infection in the anogenital area. Exclude other wart like lesions such as verrucca valgaris, condylomata lata etc. 5. Genital ulcer - ulcerative lesions in the anogenital area. 6. Rash - refers to any skin rash in the anogenital area 7. Pelvic tenderness – this is found only in female clinic form. Found during abdominal examination and/or bimanual examination/cervical motion tenderness. 8. Scrotal swelling – this is found only in male form. 9. Others - refers to any other relevant sign in the anogenital area which do not belong to above categories. 10. Not examined. (e.g. patient refused examination). If the examination is deferred, complete this section on the next visit. **Note:** *Menstruation is not a valid reason for deferring the genital examination.*
25	Circumcision	To be circled as appropriate. **Note:** This should be an examination finding as patient's history may not be reliable all the time.

L.P.U (in the space provided for notes on upper right of page 3), refers to last passed urine in hours (found only in male form)

INVESTIGATIONS

The investigations carried out are given from items 26-47. When they are ordered, circle the variable number. If not ordered or not relevant, circle value number 1 "not done/NA"
Note: If an investigation is deferred or to be done on a subsequent visit (But relevant to the same episode of care), use the same variables given for investigations.

26	FPU deposit Gram's stain	Refers to Gram stain of **first pass urine** deposit and microscopic examination under 1000 magnification (oil immersion) for quantification of number of pus cells. 1. Not done/NA – when not done or not applicable 2. Pus cells <10 – when the number of pus cells are from 0-9 3. Pus cells ≥10 – when the number of pus cells are 10 or greater than 10 4. Other – for any other findings e.g. presence of trichomonas. **Note:** If patient returns for EMS (early morning sample), and a positive result is found, replace the previously negative result and write the date.
27	Dark ground	Refers to finding of organisms morphologically resembling *Treponema pallidum* on dark ground examination. If a positive result is obtained on a subsequent sampling (as a part of 3 consecutive dark ground examinations), replace the negative with the positive result and write the date.
28	Giant cells	Results of the Giant cell examination in a smear taken from an ulcer in the anogenital area using Giemsa stain. Disregard giant cell reports from non-anogenital lesions e.g. oral lesions
29	Urethral smear	**Multiple answers are possible.** 1. Not done – when the test was not done. 2. ICGND - Circle the response if Intra cellular gram negative diplococci are present, if extra cellular gram negative diplococci are present mention it under the response of "Other" 3. <5/NAD pus cells per field under 1000 magnification or when the smear is normal 4. 5 -9 pus cells per field under 1000 magnification. 5. 10 ≥ pus cells per field under 1000 magnification. **Note:** If patient returns for EMS (early morning sample), and a positive result is found, replace the previously negative result and write the date.
30	Urethral GC Culture	Indicate gonorrhoea culture results. This will be entered during the next follow up visit. In case of a test of cure (TOC) for GC on a subsequent visit, write the result in the appropriate follow up visit. If the TOC becomes positive following a fresh exposure, it is an indication to a start new episode of care form.

31	Urethral Chlamydia	Indicate urethral chlamydia results. Chlamydia antigen detection is usually done by ELISA technique. (Other reliable tests can also be used)
32	Vaginal smear	**Multiple answers possible.** 1. Not done 2. Negative - smear shows normal vaginal flora (predominantly lactobacilli or "lactobacilli seen" as in NSACP reporting system) in Gram stained smear under 1000x magnification. 3. ICGND – if intra cellular gram negative diplococci are seen 4. Candida – if candida identified 5. Trich – if trichomonads identified 6. Clue cells – if clue cells identified (without considering the percentage of clue cells) 7. Lactobacilli not seen – when the microscopy report indicates lactobacilli not seen. 8. 6 & 7 – if clue cells are present and lactobacilli are not seen. 9. Other – for any other comments.
33	Cervical smear	1. Not done – if cervical smear was not done or not relevant. 2. ICGND – If Intra Cellular Gram Negative Diplococci are identified 3. Pus cells <30 – if number of pus cells are less than 30. 4. Pus cells≥30 – refers to number of pus cells per field in Gram stained cervical smear under 1000x magnification. 5. Other – for any other comments.
34	Cervical GC Culture	Indicate cervical GC culture results.
35	Cervical Chlamydia	Indicate cervical chlamydia results. Chlamydia antigen detection is usually done by ELISA technique. (Other reliable tests can also be used)
36	PAP smear	Pap smear recording from 2-9 done according to the guidelines of the college of pathologists of Sri Lanka. 1. Not done –Pap smear not done during this episode of care 2. Unsatisfactory –The smear is unsatisfactory for interpretation 3. NILM – Negative for Intraepithelial Lesion or Malignancy 4. LSIL – Low grade Squamous Intraepithelial Lesion 5. HSIL - High grade Squamous Intraepithelial Lesion 6. ASCUS – Atypical Squamous Cells of Undetermined Significance 7. AGC – Atypical Glandular Cells 8. BEC >40yrs – Benign Endometrial Cells in a women of more than 40 years 9. SGM – Squamous or Glandular Malignancy 10. Koilocytes – when koilocytic changes are identified. 11. TV – Trichomoniasis 12. Clue cells – when clue cells present 13. Candida – when candida is present 14. NSI/Other – Non specific inflammation/ Any other changes 15. Report NA – when report is not available
37	Throat GC culture	Indicate throat GC culture results.
38	Rectal GC Culture	Indicate GC culture results from rectum.

39	HSV Ag ELISA	Indicate results of herpes antigen detection by ELISA technique from an anogenital lesion. Disregard results from non-anogenital lesions e.g. oral lesions
40	HSV Culture	Indicate results of herpes culture results from an anogenital lesion. If positive and typing done - indicate HSV type by underlining.
41	HSV Serology	Indicate results of herpes serology results.
42	VDRL	1. Not done for this episode. 2. Tested and the result is non reactive. **Note:** If there are risk exposures during last 3 months, repeat test should be done after a period of 3 months from that risk exposure rather than 3 months from the date of registration (to cover the incubation period of syphilis). 3. Prev. reactive. VDRL result is positive but history/documents indicate previously treated syphilis e.g. follow up VDRL results. It is important to circle this value number correctly to avoid unnecessary multiple diagnoses of syphilis. 4. Reactive - If reactive VDRL test for the first time or four fold rise from the baseline (treated) VDRL titre. Enter the routine VDRL result. If only an urgent VDRL is done indicate the result. If both urgent and routine tests are done, mention the urgent VDRL result in the space provided for "other tests". **Note:** Monthly VDRL tests for initial 3 months are indicated only for those who are diagnosed and treated for early syphilis or specifically indicated for an individual patient with risk factors. During this follow up period, VDRL test becomes newly reactive (seroconversion) or four fold rise is noted, a new episode of care form has to be added. CSF-VDRL test results should be mentioned under space provided for "other tests"
43	TPPA / TPHA	1. Not done for this episode. 2. Tested and the result is non reactive 3. Prev. reactive. TPPA result is positive but history/documents indicate previously treated syphilis. It is important to mark this item correctly to avoid unnecessary multiple diagnoses of syphilis. 4. Reactive - If reactive TPPA test for the fist time. 5. Equivocal – as indicated in the laboratory report. 6. Report not available. CSF-TPPA/TPHA should be mentioned under "Other test"

44	HIV Screening test	HIV screening test include HIV antibody detection by ELISA or particle agglutination (e.g. Serodia) 1. Not done – if the test not done 2. Negative – if HIV test is negative **Note:** If there are risk exposures during last 3 months, repeat test should be done after a period of 3 months from that risk exposure rather than 3 months from the date of registration. 3. Prev. positive - If HIV result is previously known to be positive. 4. Positive - If newly detected as HIV positive in the present episode of care. 5. Inconclusive – when the test result is inconclusive
45	HIV confirmatory test	HIV confirmatory test include antibody detection by Western blot or Lineblot assays. 1. Not done – when the test is not done or not relevant. 2. Negative – when the test is negative. 3. Known positive – if the patient is already diagnosed. 4. Positive – when the HIV is identified in the present episode. 5. Inconclusive - when the test is inconclusive/ indeterminate 6. Report NA – when the report is missing or not available.
46	HBs Ag (Hepatitis B surface antigen)	1. Not done – when the test is not done 2. Negative – when the test is negative. 3. Prev. positive - If HB s Ag result is previously known to be positive by reliable history/documentary evidence 4. Positive – Result is positive for the first time during this episode. 5. Report not available.
47	Hepatitis C antibody test	1. Not done – when the test is not done. 2. Negative – when the test is negative. 3. Prev. positive - If the test result is previously known to be positive by reliable history/documentary evidence 4. Positive – Result is positive for the first time during this episode. 5. Report not available.

Note section on the Left side of page 3

Other tests

Indicate if any other tests that are not listed above. e.g. urine sugar, urine full report, investigations for opthalmia neonatorum, skin scrapings for candida, CSF-VDRL, CSF-TPPA, urgent VDRL test (see notes on item 42. VDRL)

Management/Treatment

Give details of the management and drugs prescribed

Note section on the right side of page 3

If your diagnosis is Gonorrhoea, Chlamydia, Syphilis, NGU*/NGC*, PID*, or Trichomoniasis send that index patient for an interview (FI) with the PHI/PHNS for contact tracing and to issue a contact slip number. PHI/PHNS is responsible for giving contact slips for contacts/partners identified during the interview.

Note: Partner notification for NGU/NGC and PID should be done only when the causative agent is suspected to be sexually transmitted.

Assessment / Provisional Diagnosis

Indicate the preliminary diagnosis at the first visit. Later, the final diagnosis can be entered here once the laboratory results are available.

Follow up variable at initial consultation (Page 3).

Circle the appropriate value number.

1. None/Optional- This should be used sparingly as at least one follow up visit is needed for almost all patients. However, there may be instances to select this option. e.g. A patient presents with pearly penile papillae with no sexual exposures, a person who goes abroad on the following day and unable to come for a follow up visit.
2. Yes – Mention the date and reason for follow up as this will facilitate the doctor seeing the patient on the second visit to know what needs to be done promptly. e.g. Repeat dark ground examination, EMS etc.

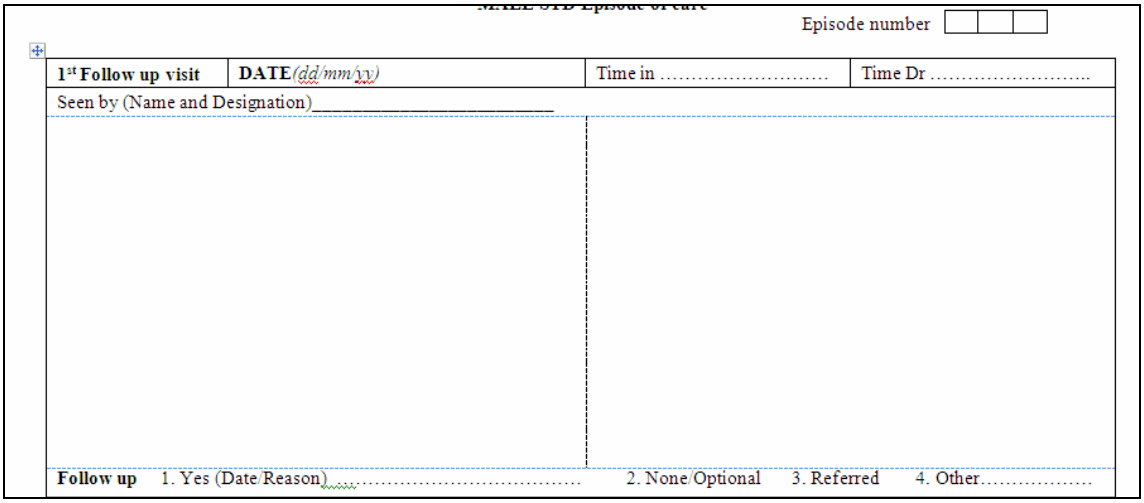
Notes checked by SMO 1

This space is provided for the SMO I to sign, once the clinic notes are checked for any missing information (failure to circle value numbers). If there are missing information, contact the relevant doctor (who consulted the patient) and try to fill the missing information on the same day. If this is not possible, instruct him/her to fill the information when the patient comes for the next follow up visit. Pasting a sticky note will facilitate this process .SMO 1 should check whether the partner management is done and take appropriate actions.

Write the name of SMO 1 as it indicates that the notes have been checked by a particular SMO 1.

Male/Female PATIENT FORM – EPISODE OF CARE (PAGE 4)

The episode number to be carried over from previous page.



This page provides space for 3 follow up visits. Write details in two columns to have more writing space.

Follow up visit boxes

Date – In this format. dd/mm/yy
Time In: The time patient presents at the reception. To be filled by reception (PHI/PHNS room)
Time Dr: The time patient came to doctor. To be filled by doctor.

Seen by: Indicate name and designation of the consulting doctor.

Follow up: Circle the appropriate value number.

1. Yes- Write date and reason
2. None/Optional
3. Referred. Use when a patient is referred to another healthcare facility and do not need further follow up for this episode of care. If this value number is circled, the file should be completed by SMO 2 and sent for data entry.

The same procedure should be followed, with follow up visits 2-3.

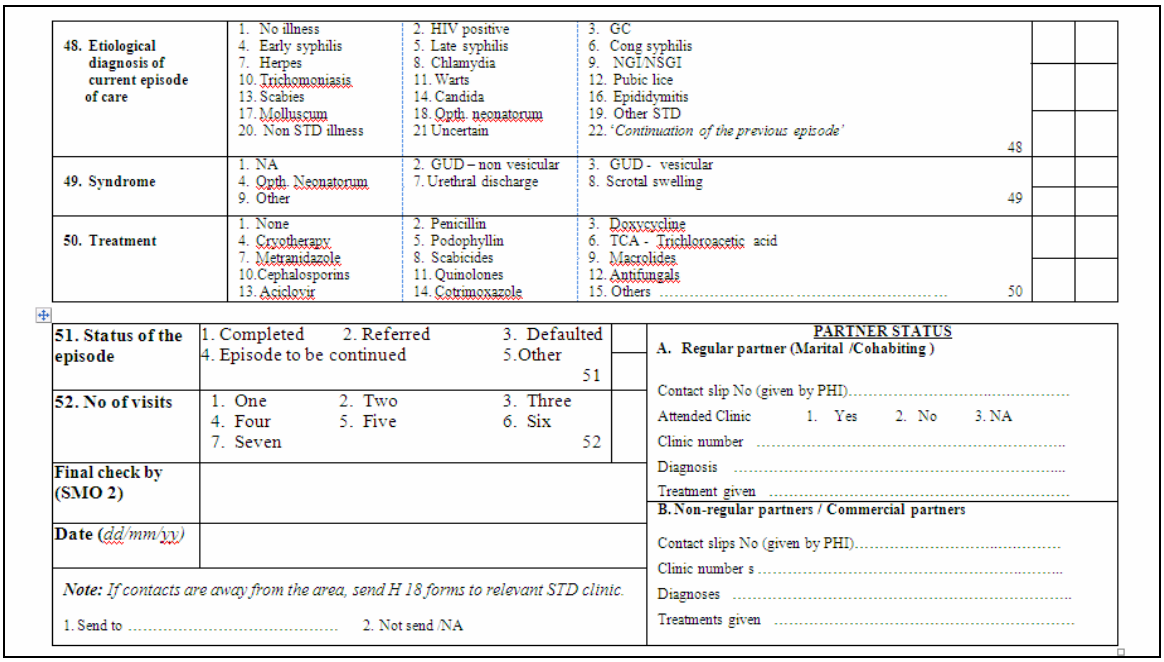
Male/Female PATIENT FORM – EPISODE OF CARE (PAGE 5)

The episode number to be carried over from previous page.

Upper half of the page 5 gives space for 4th and 5th Follow up visits. Apply same procedure described for 1st follow up.

COMPLETION OF THE EPISODE OF CARE

Once the follow up is completed or all five follow up visit cages are used, this section should be completed by SMO 2 and the patient form is sent for data entry.



48. Etiological diagnosis of current episode of care	1. No illness 4. Early syphilis 7. 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. Cong syphilis 9. NGI/NSGI 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		**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 .....
52. No of visits	1. One 2. Two 3. Three 4. Four 5. Five 6. Six 7. Seven 52		
Final check by (SMO 2)			**B. Non-regular partners / Commercial partners** Contact slips No (given by PHI)..... Clinic number s ..... Diagnoses ..... Treatments given .....
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			

Indications for completion of an episode of care

1. **Follow up care completed:** Further follow up is not necessary/optional or referred to another health facility.

2. **All spaces for follow up visits used:** Patient has attended for more than 5 follow up visits e.g. ongoing treatment for warts

3. **Next appointment ≥ 3 months later**: The appointment is given for follow up visits (e.g. serological tests for Syphilis or HIV, Pap smear) for which the time gap is 3 months or more from the last follow up date.

4. **Defaulted ≥ 3 months:** The patient has defaulted more than 3 months from the date of last appointment.

Note: If a repeat test is required as a part of the same episode of care e.g. EMS for NGU, Test of cure for GC, TV, monthly VDRL, same episode of care form could be continued. However, if a test becomes newly positive, it should be considered as a new episode of care (A new form should be attached and all relevant variables/values should be circled)

48	Etiological Diagnosis	**Multiple responses possible.** Indicate etiological diagnosis as defined in the STI case definitions given in the annexes. 1. No illness – when there is no illness 2. HIV positive- mark only if the confirmatory test is positive for the first time during this episode of care. Do not mark for patients previously diagnosed. 3. GC – Gonorrhoea 4. Early syphilis – include primary, secondary or early latent syphilis. 5. Late syphilis – include late latent syphilis, latent syphilis of unknown duration, gummatous, cardiovascular or neurosyphilis. 6. Congenital syphilis – include both early and late 7. Herpes – include only anogenital lesions 8. Chlamydia 9. NGU/NGC - Non Gonococcal Urethritis/ Non Gonococcal Cervicitis 10. Trichomoniasis 11. Warts- include only anogenital lesions 12. Pubic lice 13. Scabies 14. Candida 15. Bacterial vaginosis 16. Epididymitis 17. Molluscum 18. opthalmia neonatorum 19. Other STD – e.g. Granuloma inguinale, Lymphogranuloma venereum etc., circle and write the diagnosis. 20. Non STD illness – when the presenting illness is not classified as STD e.g. inguinal hernia, hydrocele, psoriasis, lichen planus etc. 21. Uncertain - when the diagnosis is uncertain 22. *Continuation of the previous episode* –When the current episode is a part of a previous episode of care and no new diagnosis is made during this episode eg. persistent NGU, persistent genital wart or follow up VDRL for diagnosed syphilis Note: Mark this accurately as it is important to avoid erroneous multiplication of the same STD.
49	Syndrome	**Multiple options are possible.** Indicate the syndromic diagnosis under this item. This is to be completed even where an etiological diagnosis has been made. E.g. If gonococcal urethritis was diagnosed after a positive gonococcal culture result, still circle option 7 if symptomatic (i.e. urethral discharge was a symptom) 1. NA- if the patient is asymptomatic 2- 8. Indicate the appropriate syndrome/s (only relevant options are available in male and female forms) 9. Other – Any other symptoms that do not belong to the list of syndromes given above (2-8). e.g. rash in the genital area, dysuria without discharge etc.
50	Treatment	**Multiple answers possible.** 1. None – when no treatment is given. 2-14 Indicate all treatment given during this episode of care. Also include prescriptions given for outside purchasing. 15. Others –if not in the list. Should be specified.

51	Status of the episode	1. Completed – Circle this response when the episode is completed. (Follow up option marked as "none/optional") 2. Referred – If the patient is referred to another health care facility or to another STD clinic and doctor decide to close the current episode of care. 3. Defaulted – If the current episode completed as a result of default. (Not attended for 3 months from the date of the follow up appointment given) 4. Episode to be continued – Circle this response when the previous episode is not complete and further follow up in the STD clinic is necessary. e.g. persistent NGU, ongoing treatment for warts 5. Other – for any other reason doctor decided to close the current episode of care. e.g. patient take permission to leave the country for more than 3 months.
52	Number of visits	Mention the number of clinic visits during this episode of care. If the patient has attended all five follow up visits, the number of clinic visits will be 6.

Final check by SMO 2

This section should be completed carefully to ensure validity of data.

Final check by (SMO 2)	
Date (dd/mm/yy)	

Once the episode of care is completed, SMO 2 should scrutinise the patient form from the first page and finalise for data entry.

The SMO 2 will,

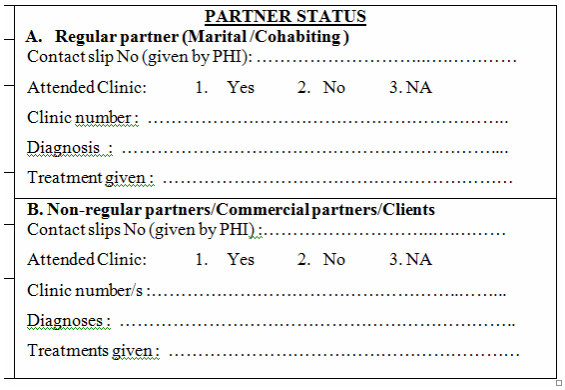
1. Write the number of the circled values of each variable in the coding box.
2. Make sure all the investigation results are circled.
3. Decide all the diagnoses of the current episode of care, syndrome/s, treatment/s, status of the episode and number of visits. Then circle the appropriate value numbers and fill in the coding boxes of variable 48-52.

Final check by SMO 2 -This space is provided for the SMO 2 to write the name and signature.
Date (dd/mm/yy) - this is the date of final check by the SMO 2.

0PARTNER STATUS

This section should be filled by PHI/PHNS. Seek instructions from SMO 2 when necessary. STDs which require contact tracing by PHI/PHNS are Gonorrhoea, Syphilis, NGU*/NGC*, PID*, and Trichomoniasis. (For any other STDs, doctor may decide to issue a partner referral note, but these should **not** be included in this section)

** Note: Partner notification for NGU/NGC and PID is relevant only when the causative agent is suspected to be sexually transmitted.*



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) : ……

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

Clinic number/s : ……

Diagnoses : ……

Treatments given : ……

Section A. Regular partner [marital or cohabiting (live-in partners)], this also includes same sex relationships.

Contact slip No: This is the number given by PHI/PHNS from the contact tracing register for regular partners.

Attended clinic: 1. Yes - If the regular partner attended the clinic,
2. No - If the regular partner not attended the clinic
3. NA – Patient does not have a regular partner

Diagnosis : Diagnoses of the regular partner.
Treatment given : Treatments given to the regular partner

Section B. Non-regular partners/Commercial partners/Clients of sex workers

Contact slip No: This is the number given by PHI/PHNS from the contact tracing register for Non-regular partners/Commercial partners/clients of sex workers.

Diagnosis : Diagnoses of the Non-regular partners/Commercial partners.

Treatment given : Treatments given to the Non-regular partners/Commercial partners.

Note: If the contacts are away from the PHI/PHNS area – Health -18 form could be sent to relevant STD clinic and indicate in the space given.

Data entry

Once SMO 2 completes the patient forms, they should be sent for data entry. when data entry is completed, the forms should be crossed with a red pen to indicate the completion of data entry. Such forms should not be changed as it will not go to the database). Then the file should be stored in "completed file" section of the record room.

Annex 1

STI case definitions for Patient Information Management System (PIMS)

<table>
<tr><td>1.HIV infection</td><td>Demonstration of antibodies to HIV 1 or 2 by a screening test,
and
confirmed with a Western blot or other confirmatory assay.</td></tr>
<tr><td rowspan="3">2. Infectious syphilis</td><td>Includes primary syphilis, secondary syphilis and early latent syphilis. Both probable and confirmed cases should be included.</td></tr>
<tr><td>a) Primary and secondary syphilis

Probable: An illness with ulcers (primary) or mucocutaeous lesions (secondary) clinically suggestive of syphilis and a reactive serologic test for syphilis (non-treponemal or treponemal).
Confirmed: Demonstration of Treponema pallidum in clinical specimens by darkfield microscopy or other methods.</td></tr>
<tr><td>b) Early latent syphilis

No clinical signs or symptoms of syphilis with historical/ documented evidence that the infection was acquired within the previous 24 months,
and
1) a reactive non-treponemal and treponemal test in a patient with no prior syphilis diagnosis, or
2) a non-treponemal test titer demonstrating fourfold or greater increase from the last non-treponemal test in a patient with a prior syphilis diagnosis.</td></tr>
<tr><td rowspan="3">3. Late syphilis</td><td>Includes late latent syphilis, tertiary syphilis, and quaternary syphilis</td></tr>
<tr><td>a) Late latent syphilis

No clinical signs or symptoms of syphilis, with evidence that the infection was acquired more than 24 months ago or of unknown duration,
and
a non-treponemal test which is reactive or non-reactive and a treponemal test which is reactive in a patient with no prior syphilis diagnosis.</td></tr>
<tr><td>b) Tertiary syphilis / quaternary syphilis

A diagnosis of cardiovascular, neuro or gummatous syphilis,
and
1) there is evidence that the infection was acquired more than 24 months ago or of unknown duration ,
and
2) a non-treponemal test which is reactive or non-reactive and a treponemal test which is reactive</td></tr>
</table>

4. Early congenital syphilis	*Early congenital syphilis is diagnosed in children who are **less than 2 years of age**. Both probable and confirmed cases should be included.*
	Probable: 1. An infant whose mother had untreated or inadequately treated syphilis during pregnancy (includes an infant whose mother treated with non-penicillin regimens and was treated for syphilis less than 4 weeks prior to delivery and regardless of signs in the infant and), **or** 2. An infant or child with a reactive treponemal test, **and,** any one of the following a) Evidence of congenital syphilis on physical examination b) Long bone X-rays compatible with congenital syphilis c) Reactive non-treponemal test, which is 4 four fold greater than the mother. d) A reactive CSF- VDRL or an elevated cell count and protein in CSF (without other cause) e) A reactive syphilis specific Ig M antibody test f) A persistently reactive treponemal test for more than 18 months of age. 2. Stillbirth: A foetal death that occurs after 20 weeks gestation or in which the foetus weighs >500 g and the mother had untreated or inadequately treated syphilis at delivery. Confirmed: Demonstration of *T. pallidum* by darkfield microscopy, fluorescent antibody in specimens from lesions, placenta, umbilical cord or autopsy material.
5. Late congenital syphilis	*Late congenital syphilis is diagnosed in persons who are older than 2 yrs.*
	1. A child with, a reactive treponemal test, whose mother had untreated or inadequately treated syphilis during pregnancy (regardless of signs in the child), **or** 2. A child with a reactive treponemal test and any one of the following a. Evidence of congenital syphilis on physical examination b. Long bone X-rays compatible with congenital syphilis
6.1 Gonorrhoea	*Both probable or confirmed cases should be included*
	Probable: 1. Male with a purulent urethral discharge who has a history of recent sexual exposure, **or** 2. Observation of gram-negative intracellular diplococci in a urethral smear obtained from a man, **or** 3. Observation of gram-negative intracellular diplococci in a cervical smear obtained from a woman, **or** 4. Sexual contact of a case of gonorrhoea (probable or confirmed) who has been treated for gonorrhoea but tested negative or not tested for gonorrhoea Confirmed: Isolation of typical gram-negative, oxidase-positive diplococci from a gonococcal culture of a clinical specimen.

7. Ophthalmia neonatorum	*Both probable or confirmed cases should be included*	
	Probable:	Unilateral or bilateral conjunctivitis in a newborn occurring within four weeks of delivery.
	Confirmed:	Conjunctivitis in a new-born (within four weeks of delivery), with an ocular specimen that is positive for *N. gonorrhoea* or *C. trachomatis*
8.1 NGU (Non-gonococcal urethritis)		A male with symptoms or signs of urethritis, **and** a urethral smear or culture is negative for gonococcus, **and** Gram-stained urethral smear with ≥ 5 pus cells per high power field (x1000), **or** Gram-stained deposits of first passed urine (centrifuged) with ≥ 10 pus cells per high power field (x1000), **or** first void centrifuged urine with ≥ 15 pus cells per high power field (x 400)
8.2 NGC (Non-gonococcal cervicitis) / **MPC** (muco purulent cervicitis)		A female with symptoms or signs of cervicitis, **and** a cervical smear or culture is negative for gonococcus, **and** Gram-stained cervical smear with ≥ 30 pus cells per field (x1000)
9. Chlamydia	Probable:	Contact of a case of chlamydia **and** tested negative or not tested
	Confirmed:	A positive antigen detection test, culture or nucleic acid-based test for *C. trachomatis* on a clinical specimen from a symptomatic or asymptomatic person.
10. Genital herpes	Laboratory evidence of herpes simplex virus (type I or II) from a clinical specimen form a lesion in the anogenital area (HSV ELISA, HSV culture), **or** A clinically compatible illness in the anogenital area with or without detecting giant cells. **Note:** Do not include serologically diagnosed cases who never had signs or symptoms of herpes in anogenital area.	
11. Genital warts	An illness with obvious genital or anal warts on physical examination. **Note:** Should not include koilocytic atypia on the Pap smear or areas with positive "Aceto-white" test.	

12. Chancroid	*Both probable or confirmed cases should be included* Probable: A person with genital or anal ulcers clinically suggestive of chancroid, **and** 1) No evidence of *T. pallidum* infection by darkfield examination **or** by a serologic test for syphilis performed more than 7 days after ulcer onset, **and** 2) A negative test for HSV on ulcer exudates or clinical exclusion of HSV. Confirmed: Identification of *Haemophilus ducreyi* by culture or nucleic acid test in ulcer exudates.
13. Trichomoniasis	Vaginal smear, urine deposit or pap smear is positive for *Trichomonasis vaginalis* in a person who may or may not have symptoms or signs.
14. Candidiasis	Refers to Candida vulvo-vaginitis in females and Candida balanitis in males. **Note:** Diagnosed only if the client has symptoms or signs, **and** a positive smear or culture for candida. It should not be a laboratory diagnosis alone.
15. Bacterial vaginosis	A woman with symptoms or signs **and** a vaginal smear suggestive of Bacterial vaginosis (presence of Clue cells, absence of lactobacilli, presence of mixed bacterial flora etc) . It should not be a laboratory diagnosis alone.
16. Other STI	Refers to all other STIs not listed above such as LGV, Granuloma inguinale, Molluscum in genital area, PID, prostatitis, genital scabies etc
17.1 Non STI	Refers to a non-STI illness such as dermatitis, seborrhoeic warts, sebacaeous cysts, UTI, Inguinal hernia etc
17.2 No illness	Refers to persons who come for testing but physical examination and laboratory investigations are negative.

Annex 2

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: ……………………………………………

………………………………………………………………………………

Permanent address: ……………………………………………………………………………… Phone: ……………………………………………

……………………………………………………………………………… Phone: ……………………………………………

………………………………………………………………………………

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	Sri Lankan /Foreign
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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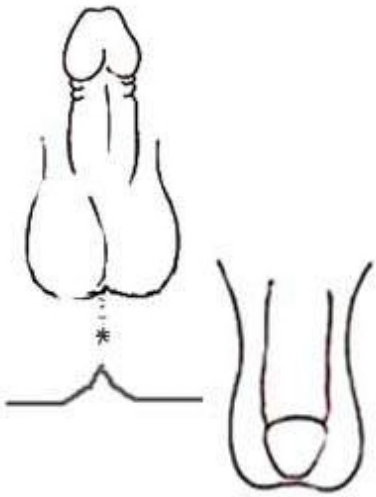
L.P.U …… Hrs ago



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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:……...
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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):……..……

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

Clinic number/s :……..……...

Diagnoses : ……..

Treatments given : ……

Annex 3

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 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. E-mail	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**

FEMALE 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.Others Ref. no..………　…………………　………………… 4	
5. Symptoms	1. None　2. Genital disch.　3. Dysuria 4. Warts　5. Genital ulcer　6. Rash 8. Pelvic pain　9. Other ………… 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	
8. Contraception	1. None/NA　2. IUCD　3. Oral 4. Condom　5. Tubal ligation　6. Injection 7. Natural　8. Others ………… 8	
9. Menstrual Cycle	1. Regular　2. Non regular　3. NA LMP…../…..... /…..　Duration/length …………………… 9	
10. Pregnant	1. No/NA　2. Yes　3. Uncertain　10	
11. Miscarriage / Still birth	1. No/NA　2. Yes G/P/C status……　…………………… 11	
12. Termination of Pregnancy (12months)	1. No/NA　2. Yes　12	
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 partners (12months)	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 last 3 months	1. NA　2. Never　3. Sometimes 4. Always　18	
19. Substance abuse (12months)	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/NGC　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	Sri Lankan / Foreign
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		

FEMALE PATIENT FORM - EPISODE OF CARE

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

EXAMINATION

24. Signs	1. None 4. Genital warts 7. Pelvic tenderness	2. Gen. discharge 5. Genital ulcer 9. Others	3. Inguinal LN 6. Rash 10. Not Exam. 24		

INVESTIGATION

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 4. 5-9 Pus cells	2. ICGND 5. ≥ 10 Pus cell	3. <5 Pus cells/NAD 6. Other 29		
30. Urethral GC culture	1. Not done 4. Report NA	2. Negative	3. Positive 30		
31. Urethral Chlamydia	1. Not done 4. Indeterminate	2. Negative 4. Report NA	3. Positive 31		
32. Vaginal smear	1. Not done 4. Candida 7. Lactobacilli not seen	2. Negative. 5. Trichomonias. 8. 6 & 7	3. ICGND 6. Clue cells 9. Other 32		
33. Cervical smear	1. Not done 4. Pus cells ≥ 30	2. ICGND 5.Other	3. Pus cells < 30 33		
34. Cervical GC culture	1. Not done 4. Report NA	2. Negative	3. Positive 34		
35. Cervical Chlamydia	1. Not done 4. Indeterminate	2. Negative 5. Report NA	3. Positive 35		
36. Pap smear	1. Not done 4. LSIL 7. AGC 10. Koilocytes 13. Candida	2. Unsatisfactory 5. HSIL 8. BEC > 40 yrs 11. TV 14. NSI/other	3. NILM 6. ASCUS 9. S/G M 12. Clue cells 15. Report NA 36		
37. Throat GC culture	1. Not done 4. Report NA	2. Negative	3. GC 37		
38. Rectal GC culture	1. Not done 4. Report NA	2. Negative	3. GC 38		
39. HSV Ag ELISA	1. Not done 4. Report NA	2. Negative	3. Positive 39		
40. HSV culture	1. Not done 4. Report NA	2. Negative	3. Positive (Type 1, Type 2) 40		
41. HSV Serology	1. Not done 4. Report NA	2. Negative	2. Positive Type1 - lgM, lgG Type 2 - lgM, lgG 41		
42. VDRL	1. Not done 4. Reactive Titre ……	2. Non reactive 5. Report NA	3. Prev.reactive (treated) Titre …..…… 42		
43. TPPA/TPHA	1. Not done 4. Reactive	2. Non reactive 5. Equivocal	3. Prev reactive(treated) 6. Report NA 43		
44. HIV Screening Test	1. Not done 4. Positive	2. Negative 5. Inconclusive	3. Prev. positive 6. Report NA 44		
45. HIV Confirmatory test	1. Not done 4. Positive	2. Negative 5. Inconclusive	3. Known positive 6. Report NA 45		
46. Hep B s Ag	1. Not done 4. Positive	2. Negative 5. Report NA	3. Prev. positive 46		
47. Hep C Ab	1. Not done 4. Positive	2. Negative 5. Report NA	3. Prev. positive 47		

Other tests:

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Management / Treatment:

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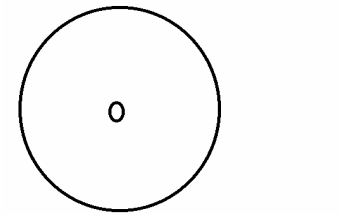

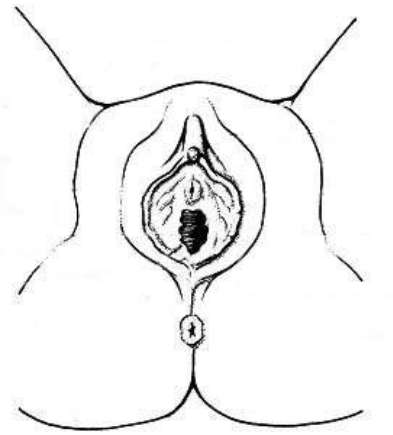

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Assessment / provisional diagnosis:

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

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

Date and reason for follow up:…..……..

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Notes checked by (SMO 1):……..……

FEMALE 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……..…

FEMALE PATIENT FORM - EPISODE OF CARE

Episode No: ☐☐☐

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 the current episodes 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 15. Bacterial vaginosis 19. Other STD 22. '*Continuation of the previous episode*' 48		
49. Syndrome	1. NA 4. Opth. neonatorum 9. Other	2. GUD – non vesicular 5. Vaginal discharge	3. GUD - vesicular 6. Lower abdominal pain 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 4. Episode to	2. Referred be continued	3. Defaulted 5.Other 51	
52. No of visits	1. One 4. Four	2. Two 5. Five	3. Three 6. Six 52	
Final check by (SMO 2)				
Date (*dd/mm/yy)*				

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

1. Send to …… 2. Not send /NA

PARTNER STATUS

A. Regular partner (Marital /Cohabiting)

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

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

Clinic number: ……..

Diagnosis: ……....

Treatment given: ……

B. Non-regular partners / Commercial partner/client

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

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

Clinic number/s ……..……..

Diagnoses: ……..

Treatments given: ……