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*

History:

……………………………………………………………………
(blank ruled lines)

SUMMARY OF SEXUAL HISTORY

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

	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 5. 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	3. 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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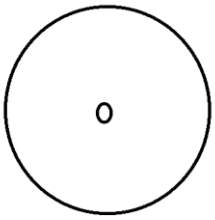

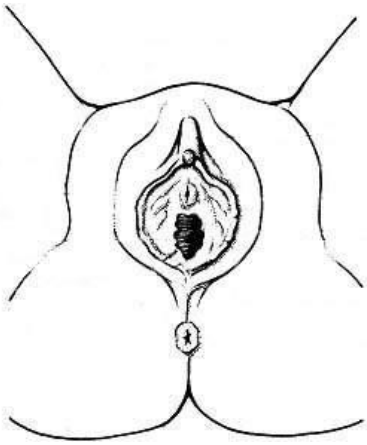

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Assessment / provisional diagnosis:

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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 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 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):……..……

Clinic number/s ……..……...

Diagnoses: ……..

Treatments given: ……