

Reporting Form: STI Medication Program

Return fax: 705-721-7848

Questions? Contact us at Simcoe Muskoka District Health – #705-721-7520 or #1-877-721-7520 ext. 8376

| Date Given yyyy/mm/dd | Patient Initials | DOB yyyy/mm/dd | Infection | Medication Given | Reason |
|--------------------------|---------------------|-------------------|--|--|---|
| | | | <input type="checkbox"/> Gonorrhoea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Syphilis | <input type="checkbox"/> Ceftriaxone 250 mg IM single dose <input type="checkbox"/> Azithromycin 250 mg x4 tablets single dose <input type="checkbox"/> Doxycycline 100 mg x14 tablets BID for 7 days Other _____ | <input type="checkbox"/> Case <input type="checkbox"/> Contact <input type="checkbox"/> Suspect case (symptoms) |
| | | | <input type="checkbox"/> Gonorrhoea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Syphilis | <input type="checkbox"/> Ceftriaxone 250 mg IM single dose <input type="checkbox"/> Azithromycin 250 mg x4 tablets single dose <input type="checkbox"/> Doxycycline 100 mg x14 tablets BID for 7 days Other _____ | <input type="checkbox"/> Case <input type="checkbox"/> Contact <input type="checkbox"/> Suspect case (symptoms) |
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|-------------------------|-------------------------------|
| Health Care Name: _____ | Contact Person: _____ |
| Office address: _____ | Telephone number: _____ |
| | Fax number: _____ (E-mail) |