**1. SURVEILLANCE SITE INFORMATION**

1.1 Clinic: {{ Clinic }}

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| **2. DEMOGRAPHIC DATA** | | | | | | | | | | |
| **2.1 Consult Date:**  {{ Consult\_Date}} | **2.2Consult Type:**  {{ Consult\_Type}} | | | | **2.3 Client Type:**  {{Client\_Type}} | | **2.4 Clinic Code:** | | **2.5 UIC/Patient ID:**  **{{Uic\_Ptid}}** | **EGASP ID: {{Egasp\_ID}}** |
| **2.6 Name:**  *First Name Middle Name Last Name Suffix* | | | | | | | | | | |
| **2.7 Birthdate:** | **2.8 Age:** | | **2.9 Sex at Birth:** | | | **2.10 Gender Identity:**  ***If other, specify:*** N/A | | | | |
| **2.11 Current Add:**    *City Province* | | | | | | | | **2.12 Permanent Add:**  *City Province* | | |
| **2.13 Nationality: *If other:***  N/A | | | | **2.14 Travel History:**  ***Please specify place of travel:*** N/A | | | | | | |
| **3. BEHAVIORAL DATA** | | | | | | | | | | |
| **3.1 History of Sex Partner:** | | **3.2 Nationality of most recent sex partner: *If other, please specify:***  N/A | | | | | | | | **3.3 No. of sex partner/s in the past month:** |
| **3.4 Sexual Behavior:**  **Urethral: Anal Insertive: Oral Receptive:**  **Vaginal: Anal Receptive: Oral Insertive: Other:** N/A | | | | | | | | **3.5 Presence of other STIs:**  **None: Hepatitis B: Syphilis: Herpes: HIV: Hepatitis C: NGI:**  **Other:** N/A | | |
| **3.6 History of illicit drug use: *Please specify:*** N/A | | | | | | | | | | |
| **3.7 Specify antibiotic used in the past two weeks:**  **Prescribed: *Please specify:*** N/A **Self-medicated: *Please specify:*** N/A  **Other: *Please specify:*** N/A **None:** | | | | | | | | | | |
| **3.8 Client/Risk Group: *If other, specify:*** N/A | | | | | | | | | | |
| **4. MEDICAL HISTORY** | | | | | | | | | | |
| **4.1 Were symptoms of gonorrhea present upon arrival to clinic:** | | | | | | | | | | |
| **4.2 Symptoms: No symptoms: Discharge from vagina: Oral/pharyngeal discharge: Tenderness in testicles: Discharge from urethra: Discharge from anus: Lower abdomen pain: Painful urination:**  **Other:** N/A | | | | | | | | | | |
| **4.3 Outcome of follow-up visit:** | | | | | | | | | | |
| **4.4 Previously Tested Positive for gonorrhea:**  ***Date of last tested positive:*** N/A | | | | | | | | **4.5 Result of Test of Cure:** | | |
| **5. TREATMENT INFORMATION** | | | | | | | | | | |
| **5.1 Gonorrhea Treatment:** | | | | | | | | **5.2 Treatment Outcome:** | | |
| **5.3 Primary antibiotic prescribed: *If other, specify:***  N/A | | | | | | | | **5.4 Secondary antibiotic prescribed: *If other, specify:***  N/A | | |
| **6. CLINIC PERSONNAL PROVIDING INFORMATION** | | | | | | | | | | |
| **6.1 Clinic Staff Name:** | | | | | | | | **6.5 Requesting Physician:** | | |
| **6.2 Telephone/Cellphone No:** | | | | | | | | **6.6 Date Requested:** | | |
| **6.3 Email Address:** | | | | | | | | **6.7 Notes:** | | |
| **6.4 Date Accomplished:** | | | | | | | |