

**Reporting Form: STI Medication Program**

**Please complete this form as you treat patients. Return immediately following treatment or with next order. Forms available: [smdhu.org/STIMedProgramForms](http://smdhu.org/STIMedProgramForms)**

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 <input type="checkbox"/> Bicillin L.A. 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 <input type="checkbox"/> Bicillin L.A. 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 <input type="checkbox"/> Bicillin L.A. 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 <input type="checkbox"/> Bicillin L.A. Other _____	<input type="checkbox"/> Case <input type="checkbox"/> Contact <input type="checkbox"/> Suspect case (symptoms)
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			<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 <input type="checkbox"/> Bicillin L.A. Other _____	<input type="checkbox"/> Case <input type="checkbox"/> Contact <input type="checkbox"/> Suspect case (symptoms)

Health Care Name: _____	Contact Person: _____
Office address: _____	Telephone number: _____
_____	Fax number: _____
	(E-mail) _____