

Care Provider STI Reporting Form

Fax To: 519-426-4767 hnhu.org

□ Chlamydia □ Gonorrhea

Client Name (Last name, First Name):	Gender⊡ Male □ T □ Female □ U	ransgender □ Other Jnknown	
Address:	DOB:		
Phone:	Date tested:		
Reason for Testing			
 Pregnant Prenatal screenin Symptoms (please specify): Other (please specify) 	g □ Contract tracing [[Client tested & treated Client treated only 	
Risk Factors (check all that apply) – HNHU wil factors	I follow-up with cases w	vith bolded risk	
 Pregnant Under 18 years of age Safety or abuse concerns Co-infection with another STI >3 STIs in the past 5 years Anonymous sex 	 No condom used Condom breakage New contact in past 2 months >1 contact in last 6 months- # Met contact through internet (app/online) Judgement impaired by alcohol/drugs 		
Medication Given (check all that apply)			
Azithromycin 1g PO in single dose	Date	Provision of treatment: □ Free treatment was	
Ceftriaxone 250 mg IM single dose	Date		
Doxycycline 100 mg PO BID for 7 days	Date	provided in office □ Rx provided to	
Other (specify reason for alternative treatment):	Date	client to take to pharmacy	
Health Teaching Provided (check all that apply) Please note: HNHU is not required to contact the client if health teaching, as outlined below, has been provided			
 STI transmission/risk reduction Abstain from sex for 7 days after completion of a single-dose treatment or until completion of multiple-dose treatment Return to clinic for re-treatment if emesis within 1 hour of taking medication Other STI/blood borne infection testing (e.g. Syphilis, HIV, Hepatitis B/C) Client informed that this infection is reportable to public health Vaccinations (Hep A/B, HPV, MPox) 			

Partner Notification (All partners within 60 days
prior to diagnosis or if no recent contacts, then
last sexual partner)

 Client is notifying partner(s)
 Client requesting confidential partner notification by Public Health

Recommended Follow-Up

- □ Routine STI testing every 3-6 months
- □ Test of cure (minimum 3-4 weeks following treatment completion)
- □ Chlamydia only recommended when compliance to treatment is suboptimal, an alternative treatment regimen is used or the person is prepubertal or pregnant
- □ Gonorrhea test of cure is recommended for all positive sites in all cases

Form Completed by: (please print) _____ Date: _____

□ I feel this client would benefit from further health teaching/support from Public Health



Publicly Funded High Risk & School Program

Vaccine Order Form

Fax To: 519-426-9246 www.hnhu.org

Refer to the Publicly Funded Immunization Schedules for Ontario for eligibility criteria

I have attached a copy of our fridge temperatures since our last order to verify that vaccine has been stored between +2° C and +8° C and min/max temperatures have been recorded twice daily.

All orders must be faxed to the Health Unit at 519-426-9246 by 12:00 p.m. on Thursday. Your order will be available for pick up on the following Thursday after 2:00 p.m. Please note, pick up time at the Health Unit are Monday-Friday between 8:45 a.m. and 4:15 p.m.•

Pick up Location

HNHU – Simcoe (12 Gilbertson Drive)

HNHU – Caledonia (100 Haddington Street)

Haldimand War Memorial Hospital – Dunnville

West Haldimand General Hospital - Hagersville

Name of Facility/Practice and Physician:

Temp log verified, attached, and order completed by:

Date:

Contact Number/Ext.

Hepatitis A (Avaxim®/Havrix®)

Name (First & Last)	DOB (YYYY/MM/DD)	HIGH RISK ELIGIBILITY > – ≥ 1 year with: (please check all that apply)	
	DOSE #: (please choose dose required)	 Chronic liver disease (including hepatitis B and C) Persons engaging in intravenous drug use Men who have sex with men Product Alternate ID 657132570 	

Haemophilus influenzae type b (Act-HIB®)				
Name (First & Last)	DOB (YYYY/MM/DD)	HIGH RISK ELIGIBILITY > – ≥ 5 year with: (please check all that apply)		
	DOSE #: (please choose dose required)	 Hematopoietic stem cell transplant (HSCT) recipient* (3 doses) Functional or anatomic asplenia (1 dose) Bone marrow or solid organ transplant recipient (1 dose) Cochlear implant recipient (pre/ post implant) (1 dose) Primary antibody deficiency (1 dose) Product Alternate ID 657132430 		



Requisition Form for Covid- 19 Vaccines

Fax To: 519-426-9246 www.hnhu.org

Healthcare Provider Name		
Address		
Anticipated date of clinic		
Requested Pick-up Date		
All orders must be faxed to 519-426-9246 by 12:00 p.m. on Thursday for pick-up the following Thursday after 2 p.m. Pick-up times are Mon-Fri. 8:45 a.m 4:15 p.m.		

*Please note fridge stability time highlighted below.

Please order the number of vials/doses required, including any vaccination supplies.

Covid-19 Vaccine	Vaccination/ Supplies /Package	Current Vials/ Doses	Doses Req.	Vials Req.
Pfizer XBB (Adult)				
Pfizer XBB (Pediatric)				
Pfizer XBB (Infant)				
Moderna XBB (6m+)				
Novavax XBB				
Vaccination Suppl	ies			
Vanish Point 1"				
1ml syringes				
5/8" needles				
1" needles				

By submitting this order, you verify the following:

- Refrigerators have maintained temperatures between +2°C to +8°C.
- Temperatures are documented twice daily, including the time the temperature was recorded.
- Accurate temperature logs are available upon request and are stored on site until your next annual cold chain inspection.
- All temperature excursions outside of +2° C to 8°C (if applicable) have been reported to the Health Unit.
- Recommendations regarding use of the affected vaccines have been implemented.
- A contingency plan is in place should a power outage and/or cold chain incident occur, including vaccine coolers and extra temperature monitoring devices.
- You understand the stability in the fridge is 30 days for Moderna products and 10 weeks for Pfizer products. This day begins from the date removed from PHU Freezer (noted on the delivery box)
- Please do not order more than 1 week prior to planned usage.

Legend: Number of doses per vaccine: Pfizer XBB? Pediatric Pfizer XBB = 6 doses, Infant Pfizer XBB/Novavax = 10 doses, Moderna = 5 doses