

PHARMACY CHLAMYDIA SCREENING ON THE ISLE OF WIGHT PATIENT GROUP DIRECTION (PGD)
CSO Tel No 01983 814285

AZITHROMYCIN		POM	
NAME			
DATE OF BIRTH (<16 yrs Fraser Competency assess)			
If under 16 refer to Sexual health Outreach Nurse (supply contact number for patient)		Phone No	
Client IWCSP Number (Without IWCSP No Refer to CSO/Sexual Health)		Index Patient <input type="checkbox"/>	Contact Patient <input type="checkbox"/>
<i>For contact patients attending with index patient please encourage completion and return of Chlamydia test and enter contact patient test number below.</i>		Test returned Yes / No (Contacts should be treated prior to testing, but encourage to complete and return test)	
Contact Patient IWCSP No			
Pharmacy Name & Address			
Date of Attendance			
If Female: LMP		Normal Cycle	
LSI		Contraception Method	
Pregnant/ Breastfeeding			Yes/ No
Is there Acute Abdominal Pain, scrotal pain (males), stinging on passing urine, discharge (vaginal or penile), concomitant conjunctivitis and/or joint pain			Yes/ No
All Clients: Current medications that interact with Azithromycin?			Yes/ No
Current serious illness			Yes/ No
Known allergies			Yes/ No
If NO to all the above questions: Supply Azithromycin 1g stat Dose If YES to any of the above refer via referral pathway If allergic to Azithromycin, refer to alternate healthcare professional see referral pathway			Yes/ No
Treatment issued: Azithromycin 1g (stat)			<input type="checkbox"/>
Batch No..... Expiry date.....			
Were you expecting a positive result?			Yes/ No
Have condoms been offered / CDS information given			Yes/ No
Has advice been given on how to take Azithromycin (see PGD)			Yes/ No
Has patient been Informed of Sexual Health Services			Yes/ No
Has patient been advised to attend Full Sexual Health Screen			Yes/ No
<i>I have discussed, where necessary, possible side effects, importance of compliance, partner treatment the need to abstain from sex for 1 week, the avoidance of antihistamines as necessary, according to treatment type supplied, and warned the patient re: interaction with the oral contraceptive pill.</i>			
Pharmacist Name:	(Please print clearly)		
Pharmacist Signature:		Date:	
Patient Signature:		Date:	
PARTNER SHEET INCLUDED	Yes / No	NO PARTNERS TO REPORT	Yes / No

CONTACT(S) INFORMATION

Please Enter Index Patient IWCSP No – [IWCSP -]

1. NAME		DOB	PHONE NO.	
ADDRESS			<input type="checkbox"/> Contact attended with Index Patient	<input type="checkbox"/> Contact card given
<input type="checkbox"/> Already screened within last month	<input type="checkbox"/> To attend Sexual Health Service	<input type="checkbox"/> Patient to contact	<input type="checkbox"/> CSP to contact	
Date 1 st Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
Date 2 nd Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
Date 3 rd Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
<u>Notes:</u>				

2. NAME		DOB	PHONE NO.	
ADDRESS			<input type="checkbox"/> Contact attended with Index Patient	<input type="checkbox"/> Contact card given
<input type="checkbox"/> Already screened within last month	<input type="checkbox"/> To attend Sexual Health Service	<input type="checkbox"/> Patient to contact	<input type="checkbox"/> CSP to contact	
Date 1 st Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
Date 2 nd Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
Date 3 rd Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
<u>Notes:</u>				

3. NAME		DOB	PHONE NO.	
ADDRESS			<input type="checkbox"/> Contact attended with Index Patient	<input type="checkbox"/> Contact card given
<input type="checkbox"/> Already screened within last month	<input type="checkbox"/> To attend Sexual Health Service	<input type="checkbox"/> Patient to contact	<input type="checkbox"/> CSP to contact	
Date 1 st Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
Date 2 nd Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
Date 3 rd Contact	<input type="checkbox"/> Letter	<input type="checkbox"/> Text	<input type="checkbox"/> Phone	
<u>Notes:</u>				

Pharmacist Date: _____
 Signature: _____
 Patient Signature: _____ Date: _____

Please Fax completed paperwork following consultation to CSO on 01983 814302.