

REPUBLIC OF KENYA



MINISTRY OF HEALTH

STI TREATMENT Data Collection Form

Date: _____ County: _____ Sub-county: _____

Ward: _____ Facility name: _____

Implementing partner: _____

1. KP name: _____ 2. Sex: Male Female 3. Age: _____

4. KP UIC: _____ 5. KP hotspot/Injecting site: _____

6. Reason for visit: Asymptomatic Symptomatic Quarterly screening checkup Follow up

7. New client in program? No Yes

8. KP type (Tick appropriate): FSW MSM MSW PWID PWUD Transman Transwoman

9. Type of syndrome/infections (tick as appropriate)

- | | | |
|---|--|--|
| 1. Genital Ulcer Disease <input type="checkbox"/> | 7. Syphilis <input type="checkbox"/> | 13. Anal Rectal Ulcer <input type="checkbox"/> |
| 2. Pelvic Inflammation Disease <input type="checkbox"/> | 8. Herpes Genitalia <input type="checkbox"/> | 14. Pharyngeal Ulcer <input type="checkbox"/> |
| 3. Candidiasis <input type="checkbox"/> | 9. Pharyngeal Discharge <input type="checkbox"/> | 15. Orchitis <input type="checkbox"/> |
| 4. Urethral Discharge/Urethritis <input type="checkbox"/> | 10. Vaginitis <input type="checkbox"/> | 16. Other (specify) _____ |
| 5. Genital Warts <input type="checkbox"/> | 11. Anal Warts <input type="checkbox"/> | |
| 6. Cervicitis <input type="checkbox"/> | 12. Anal Discharge <input type="checkbox"/> | |

10. Drug prescription (tick as appropriate)

- | | | |
|---|---|--|
| 1. Erythromycin <input type="checkbox"/> | 11. Inj. Gentamycin <input type="checkbox"/> | 21. Buscopan <input type="checkbox"/> |
| 2. Ceftriaxone <input type="checkbox"/> | 12. Amoxicillin <input type="checkbox"/> | 22. Avirax Tablets <input type="checkbox"/> |
| 3. Podophyllin <input type="checkbox"/> | 13. Doxycycline <input type="checkbox"/> | 23. Acyclovir Cream <input type="checkbox"/> |
| 4. Ciprofloxacin <input type="checkbox"/> | 14. Clotrimazole Pessaries <input type="checkbox"/> | 24. Clozole Cream <input type="checkbox"/> |
| 5. Acyclovir Tablets <input type="checkbox"/> | 15. Azithromycin <input type="checkbox"/> | 25. Other (specify) _____ |
| 6. Paracetamol <input type="checkbox"/> | 16. Avirax Cream <input type="checkbox"/> | |
| 7. Benzathine <input type="checkbox"/> | 17. Annusol Suppositories <input type="checkbox"/> | |
| 8. Spectinomycin <input type="checkbox"/> | 18. Amplicox <input type="checkbox"/> | |
| 9. Brufen <input type="checkbox"/> | 19. Metronidazole <input type="checkbox"/> | |
| 10. Cefixime <input type="checkbox"/> | 20. Fluconazole <input type="checkbox"/> | |

11. Client referred for lab. investigation: No Yes , If YES, lab investigation form no: _____

12. Client referred to other Health facilities: No Yes , If YES, to which facility: _____

13. Condom given? No Yes Num

14. Lubricant given? No Yes Num

15. Partner referral done? No Yes

16. Was genital examination done? No Yes

17. Date of next visit _____

18. Clinical Provider's comments: _____

19. Clinical Service provider's name: _____ Signature _____