

Instructions For Completion

- Questions to the patient are in lower case
- Instructions for completing this file are in CAPITAL LETTERS
- All data should be recorded using a black ink/ballpoint pen.

1. Recording text data

All text data should be entered in block capitals in the text boxes provided.

A. NURSE

2. Recording numerical data

All numerical data should be entered in the numerical boxes provided. Only one digit per box

2 2 2 2

3. Recording times and dates

All times should be entered in the boxes provided using the 24-hour clock. 12 midday should be recorded as

1 2 : 0 0

Dates should have 8 digits so 12/03/01 should be recorded as

1 2 / 0 3 / 2 0 0 1
d d / m m / y y y y

4. Correcting mistakes

Any data entered in error should be crossed out with a single oblique line and the correct data entered to the right of the data entry box with the date the amendment was made and the signature of the person making the amendment

1 2 / 0 3 / 2 0 0 1
d d / m m / y y y y

12/07/2001 A Nurse

5. Yes/No Boxes

Place a cross inside the box



6. Queries

For any queries which arise during completion contact:

Research Health Adviser
Karl Pye 0117 934 9632
 Project Manager
Anne McCarthy 0117 928 7275
 Research Associate
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Section A1:

1. Patient Initials

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2. Today's Date

		/			/					
d	d		m	m		y	y	y	y	

3. Practice Code

(1 letter and 5 digits)

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4. Method Of Referral

From study¹ Direct from GP²

- IF REFERRED FROM STUDY ANSWER **ALL** QUESTIONS
- IF REFERRED FROM GP ANSWER **UNSHADED** QUESTIONS ONLY

Section A2:**Name of person completing this form**

(BLOCK CAPITALS)

1. Surname:

2. Forename:

3. Start Time of Consultation

		:		
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(Please use 24 hour clock)

4. Nurses Code:

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Section A3: Confirm Patient Details

1. Does the patient's name and date of birth match the Appointments list?

YES¹NO²

- IF **YES** PROCEED TO **SECTION B**
- IF **NO** DO NOT PROCEED AND TELEPHONE **0117 928 7275**

Section B: Obtain Questionnaire

1. Has the patient completed and returned the case control questionnaire?

YES¹NO²

- IF **YES** OBTAIN QUESTIONNAIRE FROM PATIENT, ANSWER ANY QUERIES ABOUT THE QUESTIONNAIRE AND PROCEED TO **SECTION C**

• IF **NO**

2. Has patient already been informed of their result by Health Adviser?

YES¹NO²

- IF **YES** PROCEED TO **SECTION D**

- IF **NO** ASK PATIENT TO COMPLETE THE QUESTIONNAIRE. PROVIDE PATIENT WITH QUESTIONNAIRE, PEN AND A SEALED ENVELOPE TO PUT QUESTIONNAIRE IN ONCE COMPLETED

3. Has the patient agreed to complete the case control questionnaire?

YES¹NO²

- IF **YES** OBTAIN COMPLETED QUESTIONNAIRE FROM PATIENT, **ATTACH BARCODE** STICKER TO FRONT OF QUESTIONNAIRE, ANSWER ANY QUERIES ABOUT THE QUESTIONNAIRE PLACE IN BROWN ENVELOPE AND PROCEED TO **SECTION C**
- IF **NO** PROCEED TO **SECTION C**

Section C: Provide Patient with Chlamydia Fact Sheet

YES¹ NO²

1. Have you given the patient a Chlamydia Fact Sheet?
(see clear sleeve for Chlamydia Fact Sheet)

- IF **YES** PROCEED TO **SECTION D**
- IF **NO** PROVIDE PATIENT WITH CHLAMYDIA FACT SHEET AND PROCEED TO **SECTION D**

Section D: Confirm Repeat Sample(s)

- ASK PATIENT IF THEY HAVE TAKEN THE REPEAT SAMPLE(S) THAT THEY WERE SENT WITH THEIR APPOINTMENT LETTER, AND POSTED IT TO THE PHLs LABORATORY

YES¹ NO²

1. Has the patient taken and returned repeat sample(s)?

- IF **YES** PROCEED TO **SECTION E**
- IF **NO** PROVIDE THE PATIENT WITH SPECIMEN POT AND/OR SWAB AND REQUEST A SAMPLE

YES¹ NO²

2. Have you obtained a repeat urine sample?

3. Have you obtained a repeat vulvovaginal swab? (female participant only)

4. Record time taken
(Please use 24 hour clock)

:

- IF THE PATIENT **DECLINES** TO PROVIDE THE SAMPLE(S) **PROCEED TO SECTION E**
- IF THE PATIENT HAS **AGREED** TO PROVIDE THE SAMPLE(S)

- (1) **ATTACH PATIENT BARCODE LABEL-2** TO SPECIMEN POT AND/OR SWAB
- (2) RECORD TIME TAKEN ON 'REPEAT SAMPLE:SHEET (2)'
- (3) PLACE SPECIMEN(S) IN ClaSS SPECIMEN BOX
- (4) PLACE SPECIMEN BOX AND 'REPEAT SAMPLE: SHEET (2)' IN PADDED PRE-PAID ENVELOPE PROVIDED
- (5) POST TO PHLs AT THE END OF ClaSS CLINIC

- **PROCEED TO SECTION E**

Section E: Inform Patient of their Chlamydia Test Result

- IF PATIENT HAS ALREADY BEEN INFORMED OF A POSITIVE RESULT BY HEALTH ADVISER PROCEED TO **SECTION F**
- CONFIRM PATIENT'S NAME AND DATE OF BIRTH WITH THOSE ON THE FRONT OF THE RESULT ENVELOPE
- IF THE NAME AND DATE OF BIRTH ARE **CORRECT** OPEN THE RESULTS ENVELOPE
- IF THE NAME AND DATE OF BIRTH ARE **INCORRECT TELEPHONE** THE STUDY CENTRE **0117 928 7275**

PLEASE CROSS BOX

1. Is the patient's Chlamydia test result POSITIVE¹

NEGATIVE²

- IF **POSITIVE** PROCEED TO **SECTION F**
- IF **NEGATIVE** PROCEED TO **SECTION T**

Section F: Administer Antibiotic Treatment

- A. 1. Has patient already been treated? YES¹ NO²
- IF **YES** PROCEED TO **SECTION M**
 - IF **NO** CONTINUE WITH **SECTION F**

• Complete Checklist for the administration of Azithromycin

Azithromycin maybe contra- indicated If the patient gives a positive answer to ANY of the following questions. Please ensure that all responses are negative before administering the drug. If there are any positive answers please refer to the practice GP or use a recommended alternative.

B.		YES ¹	NO ²
1	Does the patient suffer from liver disease		
2	Is the patient allergic to erythromycin, azithromycin or clarithromycin (macrolide antibiotics)		
3	Is the patient taking any of the following: a) Terfenadine (Triludan) b) Cyclosporin c) Warfarin d) Ergot derivatives (Ergotamine, Cafergot, Lingraine, Migranal, Migril. These are all drugs for migraine, which are very rarely used these days)		
4	Is the patient pregnant or breast feeding		
5	If the patient is female, is she at risk of pregnancy		

In addition to the preceding questions, please check the following have been discussed with the patient

		YES ¹	NO ²
6	Have the side effects of Azithromycin been discussed?		
7	Has the patient read the Chlamydia Fact Sheet and have outstanding questions been discussed?		
8	Have the importance of sexual partner treatment and abstaining from sexual intercourse until their partner has been treated been understood?		
9	If taking combined oral contraceptives, has patient been advised of reduced efficacy?		
10	It is advised to take medication before food (preferably in clinic) and if taking antacids, 1 hour before, has the patient been informed of this?		
11	Have the patients details been recorded in the Antibiotic Therapy Log Book?		

- IF **ALL** OF THE RESPONSES ARE **NEGATIVE** PROCEED TO **SECTION G**
- IF **ANY** OF THE RESPONSES ARE **POSITIVE** REFER TO PRACTICE GP OR RECOMMENDED ALTERNATIVE **SECTIONS H TO SECTIONS L** (AS PER DRUG PROTOCOL)

Section G: Administration Of Azithromycin

1. Should a pregnancy test be carried out? YES¹ NO²

- IF **YES** PROCEED WITH A TEST
- IF **NO** ADMINISTER AZITHROMYCIN AS PER PROTOCOL

2. Was a pregnancy test carried out? YES¹ NO²

- IF **NO** ADMINISTER AZITHROMYCIN AS PER PROTOCOL
- IF **YES** AND THE TEST WAS **NEGATIVE** ADMINISTER AZITHROMYCIN AS PER PROTOCOL
- IF **YES** AND THE TEST WAS **POSITIVE** REFER TO THE PRACTICE GP OR USE A RECOMMENDED ALTERNATIVE AND COMPLETE **SECTIONS H TO L**

- ADMINISTER AZITHROMYCIN AS PER PROTOCOL, COMPLETE THE SECTION BELOW AND ANTIBIOTIC THERAPY LOG BOOK. OBSERVE PATIENT TAKING AZITHROMYCIN

3. **Date**
 / /
d d / m m / y y y y

4. **Time**
 :
(Please use 24 hour clock)

5. Drug Name	6. Dose	7. Form	8. Route
Azithromycin	1g (4x250mg)	Capsules	Oral

9. Administered by (Practice Nurse Signature)	10. Please PRINT NAME

- FOLLOWING ADMINISTRATION OF AZITHROMYCIN PROCEED TO **SECTION M**

11. **Comments (if any)**

Section H: Administer Alternative Antibiotic Treatment

Complete Checklist for administration of Doxycycline

Doxycycline maybe contra-indicated if the patient gives a positive answer to ANY of the following questions. Please ensure that all responses are negative before administering the drug. If there are any positive answers please refer to the practice GP or use a recommended alternative.

		YES ¹	NO ²
1	Does the patient suffer from liver disease		
2	Does the patient suffer from myasthenia gravis		
3	Is the patient allergic to tetracyclines		
4	Is the patient taking any of the following:		
	a) Anticoagulant such as Warfarin or Heparin		
	b) Antiepileptics e.g. Carbamazepine, Phenytoin, Barbiturates		
	c) Antibiotics – Penicillin, Amoxycillin		
	d) Antacids (see patient advice section)		
	e) Oral zinc or iron salts (see patient advice section)		
	f) Bismuth preparations (see patients advice section)		
5	Is the patient pregnant or breast feeding		
6	If the patient is female, is she at risk of pregnancy		

In addition to the preceding questions, please check the following have been discussed with the patient

		YES ¹	NO ²
7	Have the side effects of Doxycycline been discussed?		
8	Has the patient read the Chlamydia Fact Sheet and have outstanding questions been discussed?		
9	Have the importance of sexual partner treatment and abstaining from sexual intercourse until their partner has been treated been understood?		
10	If taking combined oral contraceptive, has patient been informed of reduced efficacy?		
11	If taking antacids, should be at least 2 hours apart from Doxycycline. Has the patient been informed of this?		
12	Has the patient been informed of possibility of photosensitivity?		
13	It is advised to take medication after food with plenty of fluid, has the patient been informed of this?		
14	Have the patient's details been recorded in the Antibiotic Therapy Log Book?		

- IF **ALL** OF THE RESPONSES ARE **NEGATIVE** PROCEED TO **SECTION I**
- IF ANY OF THE RESPONSES ARE **POSITIVE** REFER TO PRACTICE GP OR RECOMMEND ALTERNATIVE **SECTIONS J TO SECTIONS L**(AS PER DRUG PROTOCOL)

Section I: Administration Of Doxycycline

1. Should a pregnancy test be carried out? YES¹ NO²

- IF **YES** PROCEED WITH A TEST
- IF **NO** ADMINISTER DOXYCYCLINE AS PER PROTOCOL

2. Was a pregnancy test carried out? YES¹ NO²

- IF **NO** ADMINISTER DOXYCYCLINE AS PER PROTOCOL
- IF **YES** AND THE TEST WAS **NEGATIVE** PROCEED WITH ADMINISTRATION OF DOXYCYCLINE AS PER PROTOCOL
- IF **YES** AND THE TEST WAS **POSITIVE** REFER TO PRACTICE GP OR USE A RECOMMENDED ALTERNATIVE AND **COMPLETE SECTIONS J TO L**
- ADMINISTER DOXYCYCLINE AS PER PROTOCOL, COMPLETE THE SECTION BELOW AND ANTIBIOTIC THERAPY LOG BOOK
- INFORM PATIENT TO COMPLETE COURSE FOR MAXIMUM EFFECT

3. **Date**
 / /
d d / m m / y y y y

4. **Time**
 :
(Please use 24 hour clock)

5. Drug Name	6. Dose	7. Form	8. Route
<input type="text" value="Doxycycline"/>	<input type="text" value="100mg Twice Daily for 7 Days"/>	<input type="text" value="Capsule"/>	<input type="text" value="Oral"/>

9. Administered by (Practice Nurse Signature)	10. Please PRINT NAME
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>

- FOLLOWING ADMINISTRATION OF DOXYCYCLINE PROCEED TO **SECTION M**

11. **Comments (if any)**

Section J: Administer Alternative Antibiotic Treatment

Complete Checklist for the administration of Erythromycin

Erythromycin maybe contra-indicated if the patient gives a positive answer to ANY of the following questions. Please ensure that all responses are negative before administering the drug. If there are any positive answers please refer to the practice GP or use a recommended alternative.

		YES ¹	NO ²
1	Does the patient suffer from liver disease		
2	Is the patient allergic to erythromycin, azithromycin or clarithromycin (macrolide antibiotics)		
3	Is the patient taking any of the following:		
	a) Antihistamines including (Astemizole, Terfenadine (Triludan)		
	b) Antiepileptics e.g. Carbamazepine, Pheytoin, Valporate		
	c) Anti-retrovirals (HIV)		
	d) Cisapride		
	e) Cyclosporin, Tacrolimus		
	f) Anti-arythmics		
	g) Ergot derivatives (Ergotamine, Cafergot, Lingraine, Migranal, Migral		
	h) Pimoside, clozapine		
	i) Reboxitine		
	j) Theophylline		
	k) Tolteridine		
	l) Warfarin, acenocoumarol		
	m) Zopiclone		

In addition to the preceding questions, please check the following have been discussed with the patient

		YES ¹	NO ²
4	Have the side effects of Erythromycin been discussed?		
5	Has the patient read the Chlamydia Fact Sheet and have outstanding questions been discussed?		
6	Have the importance of sexual partner treatment and abstaining from sexual intercourse until their partner has been treated been understood?		
7	If taking combined oral contraceptive, has patient been informed of reduced efficacy?		
8	Has the patient been informed of possibility of photosensitivity?		
9	It is advised to take medication after food with plenty of fluid, has the patient been informed of this?		
10	Have the patients details been recorded in the Antibiotic Therapy Log Book		

- IF **ALL** OF THE RESPONSES ARE **NEGATIVE** PROCEED TO **SECTION K**
- IF **ANY** OF THE RESPONSES ARE **POSITIVE** REFER TO PRACTICE GP AND PROCEED TO **SECTION L**

Section K: Administration of Erythromycin

- ADMINISTER ERYTHROMYCIN AS PER PROTOCOL, COMPLETE THE SECTION BELOW AND ANTIBIOTIC THERAPY LOG BOOK
- INFORM PATIENT TO COMPLETE COURSE FOR MAXIMUM EFFECT

1. **Date**

		/			/				
d	d		m	m		y	y	y	y

2. **Time**

		:		
(Please use 24 hour clock)				

3. **Drug Name**4. **Dose**5. **Form**6. **Route**

Erythromycin	500mg Twice Daily for 14 Days	Tablet	Oral
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7. **Administered by (Practice Nurse Signature)**8. **Please PRINT NAME**

- FOLLOWING ADMINISTRATION OF ERYTHROMYCIN PROCEED TO **SECTION M**

Section L: Antibiotic Administration – Referral to GP or Use of a Recommended Alternative

- IF AZITHROMYCIN, DOXYCYCLINE OR ERYTHROMYCIN WERE NOT ADMINISTERED TO THE PATIENT REFER TO PRACTICE GP

YES¹	NO²
<input type="checkbox"/>	<input type="checkbox"/>

1. Was an alternative prescribed by the practice GP?

- IF **NO** PLEASE TELEPHONE STUDY CENTRE TEL: **0117 928 7275**
- IF **YES** COMPLETE THE SECTION BELOW AND ANTIBIOTIC THERAPY LOG BOOK

2. **Date**

		/			/				
d	d		m	m		y	y	y	y

3. **Time**

		:		
(Please use 24 hour clock)				

4. **Drug Name**5. **Dose**6. **Form**7. **Route**

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8. **Administered by (Practice Nurse Signature)**9. **Please PRINT NAME**

- FOLLOWING ADMINISTRATION OF ANTIBIOTIC PROCEED TO **SECTION M**