

GP REFERRED PATIENTS to Partner Notification Trial

1. Eligibility Assessment

Please Tick box

1.1. Age <input type="text"/>	1.2. Sex Male ¹ <input type="checkbox"/> Female ² <input type="checkbox"/>
1.3. Has this person received a pack or letter inviting them to take part in the Chlamydia Study? If No go to to question 7 If Yes go to question 4 Yes ¹ <input type="checkbox"/> No ² <input type="checkbox"/>	
1.4. Did patient take part in study? If No go to question5 If Yes go to question 6 Yes ¹ <input type="checkbox"/> No ² <input type="checkbox"/>	
1.5. Has patient already refused to take part? If No go to to question 7 If Yes patient is not eligible Yes ¹ <input type="checkbox"/> No ² <input type="checkbox"/>	
1.6. Did patient enter the Partner Notification Trial? If No go to to question 7 If Yes patient is not eligible. Yes ¹ <input type="checkbox"/> No ² <input type="checkbox"/>	
1.7. Does patient give consent to enter Partner Notification Trial? If No terminate discussion If Yes please turn over and proceed with Patient Details Form Yes ¹ <input type="checkbox"/> No ² <input type="checkbox"/>	

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Barcode

2. Patient Details

2.1. NHS Number

2.2. a. Practice ID Code b. Site

2.3. Patient ID code

2.4. Date of Birth

d d m m y y y y

2.5. Name

a. Title

b. Surname

2.6. Date seen

d d m m y y y y

c. Forename

2.7. (From GP Records if listed)

a. Occupation

d. Other Names

b. Code

e. Maiden Name

c. Date

d d m m y y y y

2.7. Address

a. House Name / Number

b. Street Name

c. Town / District

d. City

e. Postcode

2.8. Dispensing Practice

Yes¹

No²

Not entered³

2.9. Rural Practice

Enter Code or
leave blank

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