REPUBLIC OF KENYA

MINISTRY OF HEALTH

STI TREATMENT
Data Collection Form

Date: _____ County: _____ Sub-county: _____

Ward: _____ Facility name: _____

Implementing partner: _____

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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 programme? No ☐ Yes ☐

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

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

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

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10. Drug prescription (tick as appropriate)

1. Erythromycin ☐
2. Ceftriaxone ☐
3. Podophyllin ☐
4. Ciprofloxacin ☐
5. Acyclovir Tablets ☐
6. Paracetamol ☐
7. Benzathine ☐
8. Spectinomycin ☐
9. Brufen ☐
10. Cefixime ☐
11. Inj. Gentamycin ☐
12. Amoxycillin ☐
13. Doxycycline ☐
14. Clotrimazole Pessaries ☐
15. Azithromycin ☐
16. Avirax Cream ☐
17. Annusol Supositories ☐
18. Amplicox ☐
19. Metronidazole ☐
20. Fluconazole ☐
21. Buscopan ☐
22. Avirax Tablets ☐
23. Acyclovir Cream ☐
24. Clozole Cream ☐
25. Other (specify)_____

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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 _____