**Chlamydia treatment – supply by pharmacists**

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| Pharmacy stamp/contractor number |  | | | | | | | |
| **Patient name:** | | | | **Patient CHI number:**  If known | | | | |
| **Patient date of birth:**  **Age:** | | | | **Patient Address:** | | | | |
| **Reason for supply**  (Tick one box) | | Notification of positive chlamydia test | | | | | | |
| Partner notification ofpositive chlamydia test | | | | | | |
| **Authorisation to supply**  (Tick one box) | | Referral from sexual health advisor/ community nurse  Positive Lab test – written confirmation | | | | | | |
| Gender: | | Male/ Female/ Prefer to say | | | | |  | |
| Method of contact | | Letter / telephone/ | | | call back / best time | | |  |
| Date result received from Lab | |  | | |  | | |  |
| Chlamydia result +ve / -ve | |  | | |  | | |  |
| Gonorrhoea result + ve/ -ve | |  | | |  | | |  |
| Date patient contacted | |  | | |  | | |  |
| Reminder sent 2 weeks later minimum of 3 follow up phone calls Yes/No | | Contact 1  Contact 2  Contact 3 | | |  | | |  |
| **Inclusion and Exclusion Criteria checked** | | Inclusion | | | Doxycycline (First Line) | | | Azithromycin |
| Individuals aged 13 or over with positive uncomplicated Chlamydia diagnosis  **(excluding rectal Chlamydia: referral to Sexual Health is recommended)** | | | Individuals aged 13 or over with positive uncomplicated Chlamydia diagnosis  **(excluding rectal Chlamydia: referral to Sexual Health is recommended)** |
| Asymptomatic individuals aged 13 or over who has had sexual contact with someone with a positive chlamydia diagnosis | | | Asymptomatic individuals aged 13 or over who has had sexual contact with someone with a positive chlamydia diagnosis |
| Exclusion | | | Children under the age of 13 | | | Children under the age of 13 |
| Pregnancy or risk of pregnancy | | | Pregnancy or risk of pregnancy |
| Breast feeding | | | Breast feeding |
| Symptoms suggesting another STI or suspected complicated chlamydia | | | Symptoms suggesting another STI or suspected complicated chlamydia |
| Allergy to Doxycycline or another tetracycline or any excipients | | | Allergy to Azithromycin or any excipients |
| Taking medicines that interact with Doxycycline | | | Taking Medicines that interact with Azithromycin |
| Individuals with Myasthenia Gravis | | | Individuals with Myasthenia Gravis |
| Individuals with Lupus Erythematosus | | | The presence of rectal chlamydia |
| Individuals with fuctose intolerance, glucose-galactose malabsorption or sucrose-isomaltase insufficiency | | | Severe hepatic impairmant |
| **Medication to be supplied**  (Tick one box) | | Doxycycline 100mg capsules/tablets (14 x 100mg)(First Line)  Azithromycin 250mg capsules/tablets (8 x 250mg) | | | | | | |
| **Dose frequency and duration:** | | Doxycycline 100mg twice a day for 7 days | | | | | | |
| Azithromycin 1 gram as a single dose followed by 500mg daily for 2 days | | | | | | |
| **Consent to treatment.**  I can confirm that the information provided above is a true reflection of my individual circumstances and I give my consent to take part in the NHS A&A Community Pharmacy Chlamydia/ Gonorrhoea testing treatment/testing service and to the sharing of appropriate information with the sexual health team to allow partner notification. | | | | | | | | |
| **Signature of patient:** | | | | | | **Date:** | | |
| Contact made with sexual health team for partner notification | | | Yes/No | | | | | |

If child protection concerns are noted please contact Child Protection Service. If not competent to consent, patient should be referred to their GP or to a sexual health clinic.