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 ___________________