Partner Notification Form

Treatment site.....

Chlamydia Positive Patients ref number ..... Date..... ..

Positive patients name .....

PLEASE FAX BACK with treatment form to 08432166266. RU Clear operates Safe Haven faxing procedures.

Name of partner..... Date of birth .....

Address or area of residence .....

.....

Phone number ..... Last sexual intercourse .....

Has this person been tested for Chlamydia recently? Yes No

If yes, please state where and when tested and the result if known?

.....

Please tick

- ☐ I will tell this person that they need to take a Chlamydia test
- ☐ I will tell this person but if they have not been tested by RU Clear in 2 weeks RU Clear can call or write to them
- ☐ I want RU Clear to tell this person that they need to take a Chlamydia test
- ☐ I cannot contact this person

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