

Patient Name:				
Healthcare Facility:				
Date of Examination:				
Examining Practitioner:				
With your consent, a number of specim may call at	to discuss the			
Smear and culture for:     Gonorrhea     Chlamydia     Trichomona  4. Other (specify)	YesNo YesNo s YesNo			
You were given medication as follow:				
Name of medication	Dosage	For		
Remarks:				
You were not given any treatment med	cation because:			
You were given information/referrals fo	r the following:			
Tou were given information/referrals to	Agency		Number	
Rape Crisis Counseling				_
HIV/AIDS Counseling and Testing				
Crime Victims Compensation Other				
Other				
An appointment was made for y	ou at this hospital for follow-up me	dical treatment or	n(c	late).
An appointment was made for yo	u at this hospital for follow-up cou	nseling on	(d	late).
(Examining Practitioner Signature)				
(Patient/Parent/Guardian Signature)				

Distribution: Original in patient medical record; Copy to patient; Copy in Part A Kit box; Copy to OVS if Provider is applying for direct reimbursement