Provider Morbidity Report

Clinic Name: ___________________________________ Clinic Ph# _______________

Physician's Name: _______________________________ Clinic Fax# ______________

Person Completing Form: _________________________ Date of fax: ______________

Specimen Collection Date: _________________________

Patient Tested Positive for:

☐ **Chlamydia** ☐ **Syphilis:** RPR with titer: ___________ ☐ **Other:** ________________

☐ **Gonorrhea** Confirmatory Test *_____________________________________

***If RPR is reactive and confirmatory test is nonreactive, you are still required to report results.**

Patient's Name: ____

DOB: _____________________ SSN: _________________________

Race/Ethnicity: _____________________ Gender: ______ Pregnant: _____________

Weeks Preg: ___________

Address: ____

City: ___________________________________ Zip Code: _____________

Phone#: _______________________________

Date Treated: ____________________________

Treatment Given: ____

Please mail/fax completed report within 7 days of laboratory findings to:

Tarrant County Public Health Department
STD Surveillance Unit
1101 S. Main St., STE 1500
Fort Worth, TX 76104

Fax: 817-850-2355

Ross Tindall Ph# 817-321-4851
Catherine Martinez PH# 817-321-4864