Public Health

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

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Catherine Martinez PH# 817-321-4864