At Home STD Test

Patient Name: ______________________________ Date of Birth:________________________

Contact Info: _____________________________

Test Type:

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Other (please specify): _____________________________

Reason for Test:

- ☐ Symptoms
- ☐ Checkup
- ☐ Exposure
- ☐ Other (please specify): _____________________________

Test Results:

Date of Sample Collection: _____________________________

Sample Collection Method:

- ☐ Swab
- ☐ Urine
- ☐ Blood
- ☐ Other (please specify): _____________________________

Lab Sent To: _____________________________

Test Results:

Note: When selected, please have the words "Negative" and "Positive" underlined and bold.

- ☐ Chlamydia:
  - ☐ Negative
  - ☐ Positive

- ☐ Gonorrhea:
  - ☐ Negative
  - ☐ Positive
- ☐ Syphilis:
  - ☐ Negative
  - ☐ Positive
- ☐ Other (if applicable): ____
  - ☐ Negative
  - ☐ Positive

Result Explanation:

Date of Treatment:

Notes/Recommendations:

Patient Counseling: