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 For:

Chlamydia: ☐ Syphilis: RPR w/ Titer ☐ Other STI/STD: _____
Gonorrhea: ☐ HIV: ☐

Confirmatory Test Type _____

Confirmatory Test Result _____

Patient's Name:_____

DOB:_____ SSN:_____ Race/Ethnicity:_____

Gender:_____ Pregnancy Status: _____ Weeks Preg:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____

Date Treated:_____

Treatment Given:_____

PLEASE INCLUDE A COPY OF RELATED LABS WITH THIS REPORT

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

Tarrant County Public Health Department
STD/HIV Surveillance Unit
1101 S Main Street, Suite 1500
Fort Worth, TX 76104

Fax: 817-850-2355

Blanca Garcia-Gonzalez: Phone # 817-321-4851
Catherine Martinez: Phone # 817-321-4864

2024