|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Visit Date** | **Patient Identifier****(Medical record # or** **first and last name)** | **Patient’s** **Date of Birth** | **Patient’s Gender** **(M or F)** | **# of Chlamydia Treatment Doses Dispensed\******doxycycline*** | **# of Chlamydia Treatment Doses Dispensed\******azithromycin*** | **# of Gonorrhea Treatment Doses Dispensed\*** ***cefixime***  |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |
| 16 |  |  |  |  |  |  |  |
| 17 |  |  |  |  |  |  |  |
| 18 |  |  |  |  |  |  |  |
| 19 |  |  |  |  |  |   |  |
| 20 |  |  |  |  |  |  |  |

\*From medication supplied through Essential Access’ Chlamydia/Gonorrhea PDPT Distribution Program