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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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 |  |  |  |  |  |  |  | |
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| 10 |  |  |  |  |  |  |  | |
| 11 |  |  |  |  |  |  |  | |
| 12 |  |  |  |  |  |  |  | |
| 13 |  |  |  |  |  |  |  | |
| 14 |  |  |  |  |  |  |  | |
| 15 |  |  |  |  |  |  |  | |
| 16 |  |  |  |  |  |  |  | |
| 17 |  |  |  |  |  |  |  | |
| 18 |  |  |  |  |  |  |  | |
| 19 |  |  |  |  |  |  |  | |
| 20 |  |  |  |  |  |  |  | |

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