[Clinic Name]
[Contact Information]

[Logo]

Date: _____ / _____ / _____

Patient Name: _____

Provider: _____

Date of Birth: _____ / _____ / _____

Your Sexual Health Test Results:

Present	Absent	
☐	☐	Chlamydia
☐	☐	Gonorrhea
☐	☐	Trichomoniasis

Results provided by the Visby Medical Sexual Health test