Referral to ***DSC Clinic*** **Date of referral**……..

Dear Colleague,

…….. was seen on ……
(Patient's Name & NRIC) (Date)

and diagnosed with ……..
(Diagnosis)

Please see this patient for:

- ☐ Contact tracing
- ☐ Further education and counselling
- ☐ Follow-up (***NB:*** *A test of cure for Chlamydia is usually not indicated unless the patient is pregnant, and should not be performed sooner than 4 weeks after completion of treatment; Rescreening can be offered at 3 months*.)
- ☐ Testing of other STIs/HIV

The following tests have already been performed:

Swabs for (*please tick*):	**Result** (*please circle*):
☐ Chlamydia PCR	Negative/Positive
☐ Gonorrhoea PCR/culture	Negative/Positive
☐ Candida	Negative/Positive
☐ Trichomonas	Negative/Positive
☐ Bacterial vaginosis	Negative/Positive
☐ Other ……..	Negative/Positive
☐ Pap smear	Negative/Positive: Result……

Serology (*please tick*):	**Result** (*please circle*):	
☐ HIV	Negative/Positive	
☐ Syphilis	Negative/Positive:	VDRL/RPR……..
☐ HSV	Negative/Positive:	☐HSV-1 ☐HSV-2 ☐Both
☐ HBV	Negative/Positive:	☐Carrier ☐Natural immunity ☐Vaccinated
☐ Other……	Negative/Positive	

The patient has received the following treatment (*medication, dose, duration*):

……
……
……
……

Kind regards,

…… ……
Doctor's Name & Signature **Place of Practice**