WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

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Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

Syphilis Clinician Referral Form

Date (YY/MM/DD): _____

To: **Dr. Wajid Ahmed**, *MBBS*, *MAS, MSc, FRCPC*, Medical Officer of Health
Lindi Osborne, NP-PHC
Sexual Health Clinic, 1005 Ouellette Avenue, Windsor, ON, N9A 4J8, Fax: 226-783-2132

Patient information:

PATIENT NAME: (FIRST) (MIDDLE) (LAST)	
ADDRESS: (STREET) (CITY) (POSTAL CODE)	
HEALTH CARD #:	DOB: (YY/MM/DD)
HOME PHONE: ( ) -	ALTERNATE PHONE: ( ) -

Reason for testing:

☐ Asymptomatic with risk factors, other than contact
☐ Symptomatic
☐ Contact Tracing
☐ Routine – Prenatal Screening
☐ Routine – Medical procedure (e.g. transplant)
☐ Immigration screening
☐ Other, specify: _____

Allergies: _____

*Medical History (**Please attach a list of current medications and HIV results. If over 60 years old, provide recent creatinine and eGFR results**.):*

_____
_____
_____

History of prior syphilis infection:

1. Was client previously diagnosed with syphilis? ☐ Yes ☐ No ☐ Unknown
2. Was client previously treated? ☐ Yes ☐ No ☐ Unknown
   a. If yes, identify the medication and the date(s) the last treatment was provided.

MEDICATION NAME, DOSE, AND ROUTE	FREQUENCY	DURATION	EFFECTIVE DATE

Clinical Impression: _____

Referring Clinician's Name & Signature: _____
Clinician Referral Number: _____