

STATEMENT OF DRUGS ADMINISTERED

This form must be submitted by a facility to the West Virginia Division of STD and HIV prior to distribution of drugs by the Division to the facility. The information provided on this form will be reconciled with the Division's Central Registry.

Codes for clinic type: FP = Family Planning Clinic STD = STD Clinic

Codes for indication of treatment: S = Signs/Symptoms C = Contact P = Positive Lab

	Patient Name (Last, First)	Clinic Type		Diagnosis	Indication			Drug Name	Dose	Tx Date
		FP	STD		S	C	P			
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										

Please Complete:

Name of Facility: _____
 Address of Facility: _____
 Telephone Number: _____
 Fax Number: _____
 Person Authorized to Order Drugs: _____
 Signature: _____
 Date Submitted: _____

Division Use:

Date Order _____
 Processed: _____
 Initials: _____

West Virginia Division of STD and HIV
 350 Capitol Street, Room 125
 Charleston, WV 25301-3715
 Phone: (304) 558-2195 Fax: (304) 558-4744

Date Last Updated: 7/15/19