S.H.O.T.
(Syphilis Home Observed Treatment)
REFERRAL FORM

Referral Date:________________________

Referring Provider:____
Clinic/Agency Phone:____
Provider Best Contact: (Name/Phone #)__________________________

Patient Demographic Information

Name:____________________________________
Date of Birth:______________________________
Address:__________________________________
____

Phone Number:__________________________
Alternate Number:_______________________

Medical/OB History

Currently receiving prenatal care?
☐ Yes ☐ No ☐ Unknown
Current OB Provider:
____
OB Contact Information: __________________________
____
Gravida:________ **Para:**_________________
EDD: ___________ **EGA:** ____________(wk/day)
Last PNV:______________________________
Next scheduled PNV: ___________________

☐ **Positive Syphilis Test**
Date:____________
Result:___________
Previous Treatment ☐ **Yes** ☐ **No**
Dates of Previous Treatment: ________________
____
Complications in Current Pregnancy? ☐ **Yes*** ☐ **No**
(if yes, please list):_________________________
____
***any complication in pregnancy requires consultation with Regional Medical Director**

Program Eligibility (see SHOT information on the back side of this form for questions about program requirements)

☐ Pregnant, likely to become pregnant, or partner to pregnant woman with positive syphilis test
☐ No history of penicillin allergy
☐ Lives in area with cellular telephone coverage and access to 911 and EMS

For SHOT Program Use Only – Disposition of Referral

☐ Refused Participation ☐ Unable to Locate ☐ Did not meet criteria
☐ Treated at Health Unit ☐ Treated by Community Provider (specify) _______________________________
☐ Did not meet criteria ☐ Completed Treatment ☐ Partner Services Provided

FAX Completed Referral form to OPH STD/HIV Program Confidential FAX
(504) 568-8384