

STD MEDICATION ORDER FORM

FAX TO: (614) 387-2602

*** PLEASE COMPLETE THE ENTIRE FORM LEGIBLY ***

*** ALLOW TWO WEEKS FOR SHIPMENT ***

Date:		Name of Requesting Health Agency:			
Street Address:					
City			State		Zip
Contact Person (required):			E-Mail Address (required)		Phone:
Medication/Supply	Size	Unit	Qty. Ordered	Current Inventory	Expiration Date
1. Azithromycin	500 Mg	1 Bottle / 30 Tablets			
2. Bicillin LA	2.4 MU	1 Pack / 10 Syringes			
3. Ceftriaxone	250 Mg	1 Single Use Vial			
4. Doxycycline	100 Mg	1 Bottle / 50 Tablets			
5. Metronidazole	500 Mg	1 Bottle / 100 Tablets			
6. Acyclovir	400 Mg	1 Bottle / 100 Tablets			
7. Gentamicin Sulfa	40 Mg	2ml vials			
The Next Steps	1 Box	600 Brochures / Box			
Ohio Physician's Syphilis Pkt Guide	1 Box	100 Guides / Box			
Condoms	Package	100 Condoms/Package			

Comments:

OFFICE USE ONLY

Date Order Placed: _____

Order #: _____

STD Prevention Program
 Bureau of Infectious Diseases
 Ohio Department of Health
 Phone: 614-955-5599