Clear Form

STI/HIV CLINIC
Hawai‘i State Department of Health

HEALTHCARE PROVIDER REFERRAL FORM FOR STI EVALUATION

For an evaluation:
1. **Fax Healthcare Provider Referral Form to (808) 733-9291.**
2. **Instruct patient to make an appointment with the STI Clinic at (808) 733-9849.**

Date: _____

From: _____
(Healthcare Provider Name)

_____
(Clinic/Facility Name)

_____
(Address)

_____
(Phone and Fax Number)

To: STI/HIV Clinic
3627 Kilauea Avenue, Ste 305
Honolulu, HI 96816
Fax (808) 733-9291

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Service: _____

S:

O:
1. *Physical examination:* _____
2. *Current sign(s) and/or symptom(s):* _____
3. *History of sign(s) and/or symptom(s):* _____
4. *Current and previous syphilis serology results (**Attach** treponemal and non-treponemal antibody results, e.g., **RPR or VDRL and TPPA or EIA**)*: _____
5. *History of syphilis:* _____
6. *History of contact with infected partners:* _____
7. *Treatments rendered:* _____

A:
Syphilis stage: _____

P:

_____ MD/DO/PA/APRN
(Signature)

Updated 9/3/2025