MR # DOB

NAME

* 8 5 2 2 *

BASSETT HEALTHCARE NETWORK
Cooperstown, NY 13326-1394

POINT OF CARE WET MOUNT

H-8522 9/08;11/12;10/14;4/15;12/17 (d:\forms\hosp\.ofm)

DATE

BASSETT HEALTHCARE NETWORK

Location/Health Center _____

Address: _____

_____

Test Date: _____ Test Time: _____ Tech Initials: _____

Wet Prep Result:

Trichomonas ☐ Seen ☐ Not Seen

Yeast ☐ Seen ☐ Not Seen

Clue Cells ☐ Seen ☐ Not Seen

Reference Range:

No Trichomonas, Yeast or "Clue Cells:" seen

Provider Order
Signature: _____ Provider #: _____ Date: _____ Time: _____

Provider Review
Signature: _____ Provider #: _____ Date: _____ Time: _____

POINT OF CARE Wet Mount

White – Chart; **Yellow** – Coder