Vaginal Wet Mount POC Form

PATIENT INFORMATION	
Last Name	First Name
Date of Birth	MRN

ORDER INFORMATION	
Ordering Provider	Performed By
Documented By	Performing Location
Date Performed	Time Performed

POC RESULTS		
Bacteria	☐ Absent	☐ Present
Clue Cells	☐ Absent	☐ Present
Trichomonas	☐ Absent	☐ Present
WBC	☐ Absent	☐ Present
Yeast	☐ Absent	☐ Present