MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Nun

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
NAVHLTHCLINICPAXRIVINST 6220.1C	20 JAN 2012

LOCAL FORM TITLE *(Optional)*

POST EXPOSURE EVALUATION

Post Exposure Evaluation (mark one) ☐ 1 Week ☐ 6 Weeks ☐ 3 Months ☐ 6 Months ☐ 1 Year

Date and Time of Exposure: _____ Location of Exposure: _____

Patient Vital Signs: BP _____ P _____ T _____ RR _____ ht _____ wt _____
Pain 0-10 _____

List Medications:

Medication Reconciled: ☐ Yes ☐ No

Allergies to Medications: NKDA Yes, List: _____

Any complications since last evaluation? ☐ Yes ☐ No If yes, please explain:

Review any outstanding Patient lab work: ☐ Pending ☐ Completed ☐ N.A.

Review any outstanding Source Data lab work: ☐ Pending ☐ Completed ☐ N.A.

Assessment:

Undergoing HIV Post Exposure Prophylaxis (PEP) treatment? ☐ Yes ☐ No Remarks:

Is there evidence of HIV? ☐ Yes ☐ No Remarks:

Is there evidence of Hepatitis? ☐ Yes ☐ No Remarks:

If all lab results from source are negative no further post-exposure evaluations required.

Is further follow-up indicated? ☐ Yes ☐ No

If source is positive or unknown, draw: ☐ Hepatitis C (HCV) at 6 Months
☐ HIV at 6 weeks, 3 Months, 6 Months, and 1 Year
☐ N.A.

Patient counseling given:

Employee educated and counseled on Bloodborne Exposure Risks and PEP indications.	☐ Yes	☐ No	☐ N.A.
Employee received information on Occupational Exposure to HIV.	☐ Yes	☐ No	☐ N.A.
Employee received information on signs, symptoms and immunization side effects to report..	☐ Yes	☐ No	☐ N.A.
Employee received information on condom use, safe sex precaution to prevent re-exposure.	☐ Yes	☐ No	☐ N.A.
Employee has signed Confidentiality of Disclosure and Written Opinion signed..	☐ Yes	☐ No	☐ N.A.
Copy furnished to employee within 15 days after completion of evaluation.	☐ Yes	☐ No	☐ N.A.

Employee is responsible to contact Occupational Health for results of all tests, follow-up appointments and immunizations.

Date evaluation completed and case closed: _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	