MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

Submit Form

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

LOCAL FORM TITLE *(Optional)*

POST EXPOSURE PROPHYLAXIS REFUSAL FOR HIV

Please circle applicable wording

I have been advised that my recent exposure to blood or body fluids is associated with an INCREASED/HIGH risk of infecting me with HIV, the virus which causes AIDS. I was told that the Center for Disease Prevention and Control (CDC) and current medical practice recommend that I MAY/SHOULD take several medications used to treat the HIV virus in hopes of preventing the infection. I understand that it is strongly advised to begin these medications within 2 hours of exposures. I have decided to refuse the RECOMMENDED/OFFERED post-exposure prophylaxis, even though it may help reduce my chances of contracting HIV/AIDS.

PATIENT'S NAME	PATIENT'S SIGNATURE	DATE
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	