MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN	NAVHOSPPNCLAINST 6220.10N	16 Sep 2015

LOCAL FORM TITLE *(Optional)*
INITIAL AND FOLLOW UP FOR BLOODBORNE PATHOGEN EXPOSURE

Type of Exposure: ☐ Needlestick ☐ Sharps ☐ Splash ☐ Dermal ☐ Other (specify): _____

Date and Time of Exposure: _____ Location: _____

Circumstances of Exposure: (use reverse side if needed)

Source Lab Results: Date: _____ HBs**AG** _____ HIV _____ HIV (Rapid) _____ HCV _____

☐ Unknown Source

(Consent form required for civilian HIV testing)

Employee Lab Results: Date: _____ HBs**AB** _____ HIV _____ HCV _____ HBs**AG** _____

Employee Hepatitis B Vaccine Immunization Status: ☐ Complete ☐ Incomplete

The following immunizations were given and/or are required (include dates):

☐ Hepatitis B _____ ☐ Tetanus _____ ☐ Other (specify) _____

1. Employee educated and counseled on Bloodborne Exposure Risks. ☐ Yes ☐ No
2. Employee counseled that he/she is responsible for all follow-up labs and immunizations. ☐ Yes ☐ No
3. Employee received information on potential Occupational Exposure to BBP. ☐ Yes ☐ No
4. Employee informed and counseled regarding source lab results and acknowledges law and regulations requirements covering disclosure of the identity and infectious status of the source individual. ☐ Yes ☐ No

Patient Signature: _____ Date: _____

5. Provided a copy of Healthcare Professional's Written Opinion to patient.
6. Employee educated and counseled on PEP indications. See reverse side if yes or unknown source. ☐ N/A

CONTINUED ON REVERSE SIDE

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	

Employee received the following HIV Post-Exposure Prophylaxis (PEP):

☐ None - Specify: ☐ Not Indicated: Low Risk Exposure ☐ Employee refusal ☐ Contraindications (see comments)

☐ Basic 2 Drug regimen: **Zidovudine** (AZT, Retrovir, ZDV) 200 milligrams by mouth three times a day for 4 weeks
Lamivudine (3TC, Epivir) 150 milligrams by mouth twice a day for 4 weeks

☐ Expanded 3 Drug Regimen: Basic regimen above PLUS **Indinavir** (IDV, Crixivan) 800 milligrams by mouth twice a day for 4 weeks

Follow-up laboratory test required: ☐ Yes (check all that apply) ☐ No ☐ N/A

☐ 1 week (date)_____ ☐ CBC with Diff _____ ☐ Chem 7 _____ ☐ LFTs _____

1 week labs required only if pt. on PEP - Repeat CBC, Chem 7 and LFTs as frequently as clinically indicated while patient on PEP

☐ 6 weeks (date)_____ ☐ HIV _____ ☐ HCV _____ ☐ Hep Bs**AG** _____

☐ 3 months (date)_____ ☐ HIV _____ ☐ HCV _____ ☐ Hep Bs**AG** _____

☐ 6 months (date)_____ ☐ HIV _____ ☐ HCV _____ ☐ Hep Bs**AG** _____ ☐ LFTs _____

6 week, 3 month, 6 month labs only if unknown source or clinically indicated based on source's lab results

The employee has been informed of the results and any medical conditions arising from this exposure

☐ Phone ☐ Face-to Face

OHN Signature: _____ Date: _____

Date evaluation completed and case closed: _____

Comments:

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
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