

HIV POST-EXPOSURE PROPHYLAXIS (PEP) PHYSICIAN ASSESSMENT REPORTING FORM

This form must be filled and signed by the assigned/designated physician who will monitor the care of the patient. Ideally, this form is completed before administration of HIV PEP kits to UN Personnel who are exposed to HIV in mission and duty stations. **Complete this form and scan/email back to DHMOSH Public Health at dos-dhmosh-hiv@un.org**

PATIENT INFORMATION		
Patient Name: (First):	(Last):	Date of Birth (DD/MM/YY): / /
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Country/Location/Duty Station:	
Organization/Division/Office:		
UN Staff Index No:	Staff <input type="checkbox"/> Dependent <input type="checkbox"/> Others <input type="checkbox"/> (Please specify):	
Email Address:	Phone:	

EXPOSURE DETAILS	
When did the exposure occur?	Date: _____ Time: _____
Did the exposure occur within the past 72 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <i>NOTE: If more than 72 hours has passed since exposure, HIV antiretrovirals are <u>not</u> indicated.</i>
What type of exposure occurred?	<p>Occupational Exposure (i.e. Exposure occurred while at work)</p> <input type="checkbox"/> Needle stick injury <input type="checkbox"/> Human bite resulting in blood <input type="checkbox"/> Other exposure resulting in blood-to-blood, semen, or vaginal fluid contact If the exposure occurred while at work, is the patient who was exposed, a healthcare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Please explain: _____ <p>Non-occupational Exposure (Exposure did not occur at work)</p> <input type="checkbox"/> Unprotected sexual intercourse (vaginal or anal) <input type="checkbox"/> Use of shared needles or needle stick injury <input type="checkbox"/> Human bite resulting in blood <input type="checkbox"/> Other Please explain: _____ <p>Sexual Assault</p> <input type="checkbox"/> Potential exposure to blood semen from the assailant through an open wound or through intercourse Please explain: _____
Did the patient know the source person?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

	If the patient knew the person they were exposed to, please explain: _____
Does the patient know if the source person has HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Not applicable Date of source person's last HIV test (if applicable): _____ <input type="checkbox"/> N/A
If the source person does have HIV, does the patient know if they are currently receiving treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Not applicable Current treatment (if applicable): _____ <input type="checkbox"/> N/A
Does the source person have any of the following risk factors? [Please check all that apply]	<input type="checkbox"/> Man who has sex with men <input type="checkbox"/> Current/ ex IV drug user <input type="checkbox"/> Born or recently arrived from area of high HIV prevalence <input type="checkbox"/> Recipient of multiple blood transfusions or blood products pre-1985 <input type="checkbox"/> Sexual partner of person with risk factor(s) above
Please explain any additional exposure details or information about the source person here: _____ _____	

PATIENT HEALTH HISTORY	
Does the patient have a history of HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Date of last HIV test: _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not completed <i>If the patient does not have a history of HIV, a baseline HIV test should be completed.</i>
Was a baseline HIV test completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable Date of baseline HIV test: _____ Result of baseline HIV test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not completed If a baseline HIV test was not completed, please explain why here: _____
Is the patient pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Not applicable Date of pregnancy test: _____ <input type="checkbox"/> N/A Result of pregnancy test: _____ <input type="checkbox"/> N/A <i>PEP is not contraindicated for pregnant women. Moreover, because pregnancy has been demonstrated to increase susceptibility to sexual HIV acquisition, PEP can be especially important for women who are pregnant at the time of sexual HIV exposure.</i>

Does the patient have a history of the following health conditions (Please check all that apply):	Liver problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Bleeding problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure HIV <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Hepatitis C <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes to any of the above, please explain: _____
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TREATMENT PROVIDED TO PATIENT	
Patient took morning-after pill provided in kit	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Patient was instructed to take HIV antiretrovirals	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was the patient given the following information: <input type="checkbox"/> Education HIV antiretroviral treatment <input type="checkbox"/> Education on the importance of follow up <input type="checkbox"/> Education on the importance of finishing medication If HIV antiretroviral were not provided, what was the reason? <hr/> <p><i>If the patient was instructed to take HIV antiretrovirals, baseline liver and kidney function tests should be completed.</i></p>
If the patient was instructed to take HIV antiretrovirals, were the following baseline labs drawn?	Serum liver enzyme testing (ALT/AST) <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____ Blood Urea Nitrogen (BUN) <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____ Creatinine <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____ If no to any of the above, please explain: _____
Was the patient screened for STDs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable If no, please explain: _____ <p><i>Patients with sexual exposure should be screened for chlamydia, gonorrhea, syphilis, Hepatitis B, and Hepatitis C.</i></p> Chlamydia <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____ Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____ Syphilis <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____ Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____ Hepatitis C <input type="checkbox"/> Yes <input type="checkbox"/> No Result: _____

Was the patient treated for injuries related to the exposure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable If yes, please explain: _____ If yes, were these injuries a result of rape? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
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PATIENT EDUCATION AND FOLLOW UP

If the patient was instructed to take HIV antiretrovirals, was the following reviewed with the patient?	<input type="checkbox"/> How to take PEP <input type="checkbox"/> Potential side effects of medication <input type="checkbox"/> Importance of follow-up <input type="checkbox"/> Safer sex / condom use for 3 months <input type="checkbox"/> Safe injecting practice (if applicable) <input type="checkbox"/> Avoiding donation of plasma, blood, tissue, or semen until confirmatory negative testing <input type="checkbox"/> Not applicable
I have informed the patient to return for follow up HIV blood work in:	<input type="checkbox"/> 4-6 weeks (date _____) <input type="checkbox"/> 3 months (date _____) <input type="checkbox"/> 6 months (if co-Infection with Hep C or if HIV-2 is strongly suspected) (date _____) <input type="checkbox"/> Not applicable

Physician Name:	Signature:	Date: (DD/MM/YY): / /
Physician Email:	Contact No:	
Department/Hospital Name:		

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