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 ☐ F ☐	Country/Location/Duty Station:	
Organization/Division/Office:		
UN Staff Index No:	Staff ☐ Dependent ☐ Others ☐ (Please specify):	
Email Address:	Phone:	

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

	If the patient knew the person they were exposed to, please explain: _____
Does the patient know if the source person has HIV?	☐ Yes ☐ No ☐ Unsure ☐ Not applicable Date of source person's last HIV test (if applicable): _____ ☐ N/A
If the source person does have HIV, does the patient know if they are currently receiving treatment?	☐ Yes ☐ No ☐ Unsure ☐ Not applicable ☐ Unknown Current treatment (if applicable): _____ ☐ N/A
Does the source person have any of the following risk factors? [Please check all that apply]	☐ Men who has sex with men ☐ Current/ ex IV drug user ☐ Born or recently arrived from area of high HIV prevalence ☐ Recipient of multiple blood transfusions or blood products pre-1985 ☐ 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?	☐ Yes ☐ No ☐ Unsure Date of last HIV test: _____ Result: ☐ Positive ☐ Negative ☐ Not completed ☐ Unknown ***If the patient does not have a history of HIV, a baseline HIV test should be completed.***
Was a baseline HIV test completed?	☐ Yes ☐ No ☐ Not applicable ☐ Unknown Date of baseline HIV test: _____ Result of baseline HIV test: ☐ Positive ☐ Negative ☐ Not completed If a baseline HIV test was not completed, please explain why here: _____
Is the patient pregnant?	☐ Yes ☐ No ☐ Unknown ☐ Not applicable Date of pregnancy test: _____ ☐ N/A Result of pregnancy test: ☐ Positive ☐ Negative ☐ N/A ☐ Unknown ***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.***

Does the patient have a history of the following health conditions (Please check all that apply)?	Liver problems ☐ Yes ☐ No ☐ Unknown Kidney problems ☐ Yes ☐ No ☐ Unknown Bleeding problems ☐ Yes ☐ No ☐ Unknown HIV ☐ Yes ☐ No ☐ Unknown Hepatitis B ☐ Yes ☐ No ☐ Unknown Hepatitis C ☐ Yes ☐ No ☐ Unknown If yes to any of the above or any other information about medical history such as allergies, please describe below: _____

TREATMENT PROVIDED TO PATIENT	
Did the patient take the "morning-after pill" provided in the kit?	☐ Yes ☐ No ☐ Not applicable ☐ Unknown
Was Patient provided instructions on how to take HIV antiretrovirals	☐ Yes ☐ No ☐ Unknown If yes, was the patient given the following information: ☐ Education HIV antiretroviral treatment ☐ Education on the importance of following up with a physician ☐ Education on the importance of finishing the course of medication If HIV antiretroviral were not provided, what was the reason? _____ ***If the patient was instructed to take HIV antiretrovirals, baseline liver and kidney function tests should be completed.***
If the patient was instructed to take HIV antiretrovirals, were the following baseline labs drawn?	Serum liver enzyme testing (ALT/AST) ☐ Yes ☐ No ☐ Unknown Result: _____ Blood Urea Nitrogen (BUN) ☐ Yes ☐ No ☐ Unknown Result: _____ Creatinine ☐ Yes ☐ No ☐ Unknown Result: _____ If no to any of the above, please explain: _____
Was the patient screened for STDs?	☐ Yes ☐ No ☐ N/A ☐ Unknown If no, please explain: _____ ***Patients with sexual exposure should be screened for chlamydia, gonorrhea, syphilis, Hepatitis B, and Hepatitis C.*** Chlamydia ☐ Yes ☐ No ☐ N/A ☐ Unknown Result: _____ Gonorrhea ☐ Yes ☐ No ☐ N/A ☐ Unknown Result: _____ Syphilis ☐ Yes ☐ No ☐ N/A ☐ Unknown Result: _____ Hepatitis B ☐ Yes ☐ No ☐ N/A ☐ Unknown Result: _____ Hepatitis C ☐ Yes ☐ No ☐ N/A ☐ Unknown Result: _____

Was the patient treated for injuries related to the exposure?	☐ Yes ☐ No ☐ Unsure ☐ Not applicable If yes, please explain: _____ If yes, were these injuries a result of rape? ☐ Yes ☐ No ☐ Unsure

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

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

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