

# Healthcare Worker Postexposure Prophylaxis

\*required for saving

\*\*required for completion

*Facility ID # : _____	*MedAdmin ID # : _____
*HCW ID # : _____	
HCW Name, Last: _____ First: _____ Middle: _____	
*Gender: _____	*Date of Birth: ___/___/___
*Infectious Agent: _____	*Exposure Event # : _____
Initial PEP	
Indication: Prophylaxis	
*Regimen: _____	
*Drug: _____	*Drug: _____
*Drug: _____	*Drug: _____
*Date Started: ___/___/___	*Date Stopped: ___/___/___
*Reason for Stopping (select one):	
<input type="checkbox"/> Completion of drug therapy	<input type="checkbox"/> Source patient was HIV negative
<input type="checkbox"/> Lab results	<input type="checkbox"/> HCW choice
<input type="checkbox"/> Lost to follow-up	<input type="checkbox"/> Adverse reactions
<input type="checkbox"/> Possible anti-retroviral resistance	
*Time between exposure and first dose: _____ hours	
PEP Change 1	<i>Indicate any change from initial PEP.</i>
Indication: Prophylaxis	
**Regimen: _____	
**Drug: _____	**Drug: _____
**Drug: _____	**Drug: _____
**Date Started: ___/___/___	**Date Stopped: ___/___/___
**Reason for Stopping: _____	
PEP Change 2	<i>Indicate any change from first change in PEP.</i>
Indication: Prophylaxis	
**Regimen: _____	
**Drug: _____	**Drug: _____
**Drug: _____	**Drug: _____
**Date Started: ___/___/___	**Date Stopped: ___/___/___
Reason for Stopping: _____	
Adverse Reactions	Select all that apply:
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Flank pain
<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Headache
<input type="checkbox"/> Dark urine	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Involuntary weight loss
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Emotional distress	<input type="checkbox"/> Light stools
<input type="checkbox"/> Fever	<input type="checkbox"/> Liver enlargement
	<input type="checkbox"/> Loss of appetite
	<input type="checkbox"/> Lymphadenopathy
	<input type="checkbox"/> Malaise/fatigue
	<input type="checkbox"/> Myalgia
	<input type="checkbox"/> Nausea
	<input type="checkbox"/> Nephrolithiasis
	<input type="checkbox"/> Night sweats
	<input type="checkbox"/> Numbness in extremities
	<input type="checkbox"/> Paresthesia
	<input type="checkbox"/> Rash
	<input type="checkbox"/> Somnolence
	<input type="checkbox"/> Spleen enlargement
	<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Other (specify): _____
	<input type="checkbox"/> Unknown

**Assurance of Confidentiality:** The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-79, Atlanta, GA 30333, ATTN: PRA (0920-0666).

Custom Fields

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