

BBF Postexposure Prophylaxis (PEP)

Facility ID#: _____ MedAdmin ID# _____

*HCW ID#: _____

HCW Name, Last: _____ First: _____ Middle: _____

*Gender: F M Other *Date of Birth: ___/___/_____

*Infectious Agent: _____ *Exposure Event #: _____

Initial Postexposure Prophylaxis

Indication: Prophylaxis *Time between exposure and first dose: _____ hours

*Drug: _____ *Drug: _____ *Drug: _____ *Drug: _____

*Date Started: ___/___/_____ *Date Stopped: ___/___/_____

*Reason for Stopping (select one):

Completion of drug therapy Source patient was HIV negative Adverse reactions

Lab results HCW choice Possible anti-retroviral resistance

Lost to follow up

PEP Change 1 *Indicate any change from initial PEP.*

Indication: Prophylaxis

**Drug: _____ **Drug: _____ **Drug: _____ **Drug: _____

**Date Started: ___/___/_____ **Date Stopped: ___/___/_____

**Reason for Stopping: (select one):

Completion of drug therapy Source patient was HIV negative Adverse reactions

Lab results HCW choice Possible anti-retroviral resistance

Lost to follow up

PEP Change 2 *Indicate any change from first change in PEP.*

Indication: Prophylaxis

**Drug: _____ **Drug: _____ **Drug: _____ **Drug: _____

**Date Started: ___/___/_____ **Date Stopped: ___/___/_____

**Reason for Stopping: _____

Completion of drug therapy Source patient was HIV negative Adverse reactions

Lab results HCW choice Possible anti-retroviral resistance

Lost to follow up

Adverse Reactions

(Select all that apply):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Flank pain | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Numbness in extremities |
| <input type="checkbox"/> Arthralgia | <input type="checkbox"/> Headache | <input type="checkbox"/> Lymphadenopathy | <input type="checkbox"/> Paresthesia |
| <input type="checkbox"/> Dark urine | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Malaise/fatigue | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Involuntary weight loss | <input type="checkbox"/> Myalgia | <input type="checkbox"/> Somnolence |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Nausea | <input type="checkbox"/> Spleen enlargement |
| <input type="checkbox"/> Emotional distress | <input type="checkbox"/> Light stools | <input type="checkbox"/> Nephrolithiasis | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Liver enlargement | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Other (specify): _____ |
| | | | <input type="checkbox"/> Unknown |

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Healthcare Worker Prophylaxis/Treatment

Custom Fields

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Comments

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