Healthcare Worker Prophylaxis/Treatment

OMB No. 0920-0666
Exp. Date: xx-xx-xxxx

BBF Postexposure Prophylaxis (PEP)

*required for saving **required for completion

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):

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

Healthcare Worker Prophylaxis/Treatment

Custom Fields

Label		Label	
_____	___/___/___	_____	___/___/____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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Comments