Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Healthcare Worker Prophylaxis/Treatment

BBF Postexposure Prophylaxis (PEP)

*required for saving **required for completion

Facility ID#: _____ Med Admin 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 initial 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

Assurance of Confidentiality: The voluntarily provided 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-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Healthcare Worker Prophylaxis/Treatment

Custom Fields

Label		Label	
_____	____/____/_____	_____	____/____/_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments