



Healthcare Worker Prophylaxis/Treatment BBF Postexposure Prophylaxis (PEP)

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*required for saving

**required for completion

Facility ID#: _____	Med Admin ID#: _____
*HCW ID#: _____	
HCW Name, Last: _____	First: _____ Middle: _____
*Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> 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):	
<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

PEP Change 1 *Indicate any change from initial PEP*

Indication: Prophylaxis	
**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

PEP Change 2 *Indicate any change from initial PEP*

Indication: Prophylaxis	
**Drug: _____ **Drug: _____	**Drug: _____ **Drug: _____
**Date Started: ___ / ___ / _____	**Date Stopped: ___ / ___ / _____
**Reason for Stopping: _____	
<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

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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CDC 57.206 (Front), v6.6



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Custom Fields

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