Information Record: HIV Post-Exposure Prophylaxis

Please complete sections of this form for each patient prescribed a starter kit for post-exposure prophylaxis for HIV infection. Attach any other information that may be useful and return the completed form to:

Medical Advisor, CDC
Public Health Branch
Manitoba Health
4059, 300 Carlton Street
Winnipeg, MB R3B 3M9
Fax: (204) 948-2040

Health Facility	
Date of Exposure	Name of Provider (PLEASE PRINT)
Name of Contact Person	

SECTION I

1. Describe the exposure ______________________________

____

____

2. Number of days between exposure and initiation of chemoprophylaxis (Enter "0" if < 1): ______ If < 1 day, number of hours ______

3. Was the exposure: ☐ Occupational ☐ Non-occupational

4. What was the HIV status of the **source** at the time of the exposure? ☐ Positive ☐ Negative ☐ Source known HIV status unknown ☐ Source unknown

5. If the source was known, but the HIV status of the source unknown at the time of the exposure, was:

a) the exposure considered to be high risk? ☐ Yes ☐ No

If "yes," why? ☐ Deep percutaneous injury ☐ Visible blood on device ☐ Needle placed directly in source's vein/artery

☐ Other (Specify) ______________________________

b) a risk factor for HIV infection known to be present in the source? ☐ Yes ☐ No

If "yes," please specify risk factor(s) ______________________________

DO NOT WRITE BELOW THIS LINE

General Instructions:

This form must be completed whenever anti-retroviral drugs are issued as post-exposure prophylaxis for exposures or potential exposures to HIV infection. It contains two sections, one for initial patient assessment (parts 1 and 2) and the other for patient follow-up (parts 3 and 4).

Section I:

The first section of the form should be filled out by the physician or provider making the initial assessment of the exposure. After completing Section I, retain the top sheet (part 1) and forward the copy (part 2) to Manitoba Health at the address indicated. The rest of the form (parts 3 and 4), should be sent to the physician or provider who will handle patient follow-up.

Section II:

The second section of this form should be completed by the physician or provider handling patient follow-up. When it is filled out, retain the top sheet (part 3) and forward the copy (part 4) to Manitoba Health at the address indicated.

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SECTION II

Name of Provider	Name of Contact Person

6. If the source was not already known to be HIV positive at the time of exposure, what was the HIV status of the **source** on post-exposure testing? ☐ Positive ☐ Negative ☐ Refused Testing ☐ Source Unknown

7. Did the **exposed** complete the 5 day starter kit? ☐ Yes ☐ No ☐ Not Known

If "No," why not? ______________________________ If "No," how many days of therapy were completed? ________

8. Was the **exposed** advised to complete the full 28 days of therapy? ☐ Yes ☐ No

If "No," why not? ☐ Source tested negative ☐ Other (Specify) ______________________________

If "Yes," why? ☐ Source HIV positive ☐ Source HIV negative, but concerned about window period ☐ HIV status of source unknown, and source judged to be high risk for HIV

☐ Other (Specify) ______________________________

9. If prescribed, did the exposed complete the full 28 days of therapy? ☐ Yes ☐ No ☐ Not Known

If "No," how many days? ________

If "No," why was therapy discontinued? ______________________________

10. Was a protease inhibitor or other drug also prescribed? ☐ Yes ☐ No If "yes," which one(s)? ________

Why? ______________________________

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