

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

RESULTS OF BLOODBORNE PATHOGEN EXPOSURE INCIDENT EVALUATION

OTSG APPROVED (Date)

26 February 1997

(Complete SOAP documentation, sign, and date within 2 weeks of the bloodborne pathogen incident.)

S: Bloodborne Pathogens Exposure Incident

Date of incident: _____ Date of initial evaluation: _____ Site of exposure: _____

Route of exposure: Penetration of intact skin Contact with abraded or inflamed skin Contact with mucous membrane

Circumstances: _____

O: Clinical Evaluation of Source of Exposure

Source known: Yes No

Source able to be tested: Yes No If "No," reason: _____

Results of Source testing:

HBsAg Positive Negative Date: _____ Not tested

HIV Positive Negative Date: _____ Not tested

Hepatitis C Positive Negative Date: _____ Not tested

RPR Positive Negative Date: _____ Not tested

LFT Positive Negative Date: _____ Not tested

Other bloodborne diseases: _____

Clinical Evaluation of Patient

Hepatitis B immunity status:

HBV immune from prior infection Yes No

Has completed HBV series Yes No

Has tested Anti-HBs positive in past 12 months Yes No

Known nonresponder to HBV Yes No

Other: _____

Results of patient testing:

Anti-HBs Positive Negative Date: _____ Not tested

HIV Positive Negative Date: _____ Not tested

Hepatitis C Positive Negative Date: _____ Not tested

RPR Positive Negative Date: _____ Not tested

LFT Positive Negative Date: _____ Not tested

Other: _____

Initial patient treatment: None ISG HBIG Other (specify): _____

A. High risk HIV exposure Yes No

High risk hepatitis B exposure Yes No

High risk hepatitis C exposure Yes No

High risk other bloodborne disease exposure Yes No

P. HBV 1 Dose 2 Doses 3 Doses None Date due: _____

HBIG in one month Yes No Date due: _____

Retest for HIV at 6 weeks, 3 months and 6 months Yes No

Retest for _____ Date due: _____

Referral to Infectious Disease Yes No

Enter documentation of follow up testing on reverse.

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

HISTORY/PHYSICAL FLOW CHART

OTHER EXAMINATION OR EVALUATION OTHER (Specify)

DIAGNOSTIC STUDIES

TREATMENT

Documentation of Follow up Testing

| | | | | |
|--|---|---------------------------|---------|-------|
| 6 week HIV | <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: | Other test: | Result: | Date: |
| 3 month HIV | <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: | Other test: | Result: | Date: |
| 6 month HIV | <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: | Other test: | Result: | Date: |
| PREPARED BY (<i>Signature & Title</i>) | | DEPARTMENT/SERVICE/CLINIC | | DATE |