Information Record: HIV Post-exposure Prophylaxis

Manitoba
Health and Healthy Living

Complete this form for EACH individual receiving Post-exposure Prophylaxis (PEP) for HIV
PLEASE PRINT CLEARLY

Exposed Name OR HIV Non-nominal Code: ____________________

Provider Name: ____________________ Phone: ____________________

Health Facility: ____________________

RHA: ____________________ Date of Exposure (yyyy/mm/dd): ____________________

1. Describe the Exposure: ____________________

2. Exposure:
   - ☐ Occupational ☐ Non-occupational

3. Exposure Type:
   - ☐ Percutaneous (e.g., needlestick)
   - ☐ Mucous membrane (e.g., splash to eyes, oral cavity, etc.)
   - ☐ Non-intact skin (e.g., splash to open wound)
   - ☐ Needle-sharing (e.g., injection drug use)
   - ☐ Other: ____________________
   - ☐ Abandoned needle or sharp
   - ☐ Sexual assault
   - ☐ Unprotected sex
   - ☐ Human bite

4. Number of **hours** between exposure and initiation of chemoprophylaxis:
   - ☐ 0 – 2 ☐ 2 – 4 ☐ 4 – 12 ☐ 12 – 24 ☐ 24 – 48 ☐ 48 – 72
   - ☐ Other: ______days

5. HIV status of Source:
   - ☐ Positive ☐ Negative ☐ Unknown (e.g., source identity unknown or source unavailable for testing)

6. Type of kit prescribed:
   - ☐ Adult Basic
   - ☐ Adult Expanded (Basic kit + lopinavir/ritonavir (Kaletra®)
   - ☐ Pediatric Basic
   - Pediatric Expanded
     - ☐ Basic kit + lopinavir/ritonavir (Kaletra®)
     - ☐ Basic kit + nelfinavir (Viracept®)

7. If pediatric kit prescribed, was an ID specialist consulted? ☐ Yes ☐ No

8. Was the exposed referred for follow-up?
   - ☐ Yes ☐ No

9. If yes, exposed referred to:
   - ☐ Occupational health
   - ☐ ID specialist
   - ☐ Primary care
   - ☐ Family physician
   - ☐ Public health

Turn over to page 2

If person completing page 1 of this form is not going to provide follow-up care, please forward this form with the patient referral to follow-up care provider.

Completed by follow-up care provider: *PLEASE PRINT CLEARLY*

Exposed Name OR HIV Non-nominal Code: ______________________________

Provider Name: ______________________________ Phone: ______________________________

Health Facility: ______________________________

RHA**:** ______________________________ Date of Visit (yyyy/mm/dd): ______________________________

10. Exposed completed all drugs in starter kit(s)?
    - ☐ Yes
    - ☐ No
    - ☐ Unknown

    If no, number of days of therapy completed: ☐ 1 ☐ 2 ☐ 3 ☐ 4

11. If no to above, exposed stopped drugs because:
    - ☐ Source tested negative for HIV
    - ☐ Unable to tolerate medication
    - ☐ Other, please specify ______________________________

12. Was the Exposed advised to complete the full 28 days of therapy? ☐ Yes ☐ No

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

13. Exposed completed the full 28 days of prophylactic therapy? ☐ Yes ☐ No

    If no, why not:
    - ☐ Unable to tolerate meds
    - ☐ Other______________________________

14. If No, exposed completed ____ days of therapy

Follow-Up Care Provider – please return the completed form to:

STI/BBP Program Specialist
CDC Branch, Public Health Division
Manitoba Health and Healthy Living
4th Floor – 300 Carlton Street
Winnipeg, MB R3B 3M9

Secure Fax: 204-948-3044