

# Source Patient Encounter Form

## HEALTH CARE WORKER EXPOSURE INFORMATION

HCW ID # _____ Exposure date ____/____/____ Report date ____/____/____	<b>1. Exposure type</b> <input type="checkbox"/> Percutaneous injury <input type="checkbox"/> <i>needlestick</i> <input type="checkbox"/> <i>laceration</i> <input type="checkbox"/> <i>puncture</i> <input type="checkbox"/> Mucous membrane <input type="checkbox"/> Bite <input type="checkbox"/> Skin <input type="checkbox"/> <i>non-intact</i> <input type="checkbox"/> <i>intact</i> <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<b>2A. Is the HCW taking PEP?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> <i>AZT/3TC</i> <input type="checkbox"/> <i>ddl/d4T</i> <input type="checkbox"/> <i>other</i> _____ <b>2B. If so, was PI added?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> <i>indinavir</i> <input type="checkbox"/> <i>nelfinavir</i>
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## GENERAL SOURCE PATIENT INFORMATION

Pt. Last, First name _____ Pt ID # _____ Gender _____      DOB ____/____/____ Birth Place/Ethnicity _____	<b>1. Location at time of exposure:</b> <input type="checkbox"/> Hospital <input type="checkbox"/> <i>inpatient</i> _____ <input type="checkbox"/> <i>outpatient</i> _____ <input type="checkbox"/> <i>emergency</i> _____ <input type="checkbox"/> <i>other</i> _____ <input type="checkbox"/> Clinic/Health Center _____ <input type="checkbox"/> Other site _____ <input type="checkbox"/> Correctional facility _____ <input type="checkbox"/> Long-term care facility _____ <input type="checkbox"/> Other _____
<b>2. Pt encounter location:</b> _____  <b>3. Admitted?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>4. Pt discharged before encounter possible?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

## SOURCE PATIENT PRE-TEST EVALUATION

<b>1. Date of:</b> <input type="checkbox"/> Medical chart review    ____/____/____ <input type="checkbox"/> Patient/proxy interview    ____/____/____ <input type="checkbox"/> Clinician interview        ____/____/____	<b>2. HIV consent requested by:</b> <input type="checkbox"/> Counselor <input type="checkbox"/> Clinician _____ <input type="checkbox"/> Other _____
<b>3. Consent</b> <input type="checkbox"/> Obtained from: <input type="checkbox"/> <i>patient</i> <input type="checkbox"/> <i>proxy:</i> <input type="checkbox"/> <i>pt incompetent</i> <input type="checkbox"/> <i>pt unable</i> <input type="checkbox"/> <i>pt refused; blood in lab</i> <input type="checkbox"/> <i>close relation</i> _____ <input type="checkbox"/> <i>administrative approval</i>	<input type="checkbox"/> Not obtained because: <input type="checkbox"/> <i>unavailable</i> <input type="checkbox"/> <i>deceased</i> <input type="checkbox"/> <i>low risk</i> <input type="checkbox"/> <i>refused/no blood in lab</i> <input type="checkbox"/> <i>known HIV+</i> <input type="checkbox"/> <i>other</i> _____
	<b>4. Homeless?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <b>5. Contact address</b> _____ _____ _____
	<b>6. Contact phone number</b> _____

## SOURCE PATIENT RISK ASSESSMENT

### Substance use

<b>1A. IDU?</b> <input type="checkbox"/> Yes <i>Specify:</i> _____ <input type="checkbox"/> current <input type="checkbox"/> recent <input type="checkbox"/> past <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>1B. Share needles?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>1C. Clean needles before use?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2. Crack cocaine?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>1D. Use needle exchange?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1E. How often do you share needles?</b> <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost always <input type="checkbox"/> Rarely <input type="checkbox"/> Unknown
	<b>3. Alcohol?</b> <input type="checkbox"/> None <input type="checkbox"/> Light use <input type="checkbox"/> Heavy use <input type="checkbox"/> Unknown <input type="checkbox"/> Moderate use <input type="checkbox"/> Variable use	

### Sexual contact

<b>1. Sex with:</b> <input type="checkbox"/> Same-sex partner(s) only <input type="checkbox"/> <i>monogamous</i> <input type="checkbox"/> Opposite-sex partner(s) only <input type="checkbox"/> <i>monogamous</i> <input type="checkbox"/> Both men and women <input type="checkbox"/> Multiple partners <input type="checkbox"/> None  <input type="checkbox"/> HIV+ partner(s) <input type="checkbox"/> HAV+, HBV+, HCV+ partner(s) _____ <input type="checkbox"/> A man who has had sex with other men <input type="checkbox"/> A partner who has shared works <input type="checkbox"/> None known  <input type="checkbox"/> Other _____	<b>2. Condom use:</b> <input type="checkbox"/> Always <input type="checkbox"/> Almost always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown	<b>3. Other protection method(s) used:</b> _____
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### Transfusions/exposures to blood

<b>1. Patient has had</b> <input type="checkbox"/> Multiple blood transfusions: Dates: _____ <input type="checkbox"/> <i>coagulation disorders</i> <input type="checkbox"/> <i>renal dialysis</i> <input type="checkbox"/> <i>trauma</i> <input type="checkbox"/> <i>other</i> _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown
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### Geography

<b>1. Travel to endemic country?</b> <input type="checkbox"/> Yes <i>Where?</i> _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
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### Additional information

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### TEST DISCLOSURE

<p><b>1A. Results disclosed?</b></p> <p><input type="checkbox"/> Yes:</p> <p style="margin-left: 20px;"><input type="checkbox"/> source patient counselor ____/____/____</p> <p style="margin-left: 20px;"><input type="checkbox"/> other clinician ____/____/____</p> <p><input type="checkbox"/> No:</p> <p style="margin-left: 20px;"><input type="checkbox"/> no-show</p> <p style="margin-left: 20px;"><input type="checkbox"/> deceased</p> <p style="margin-left: 20px;"><input type="checkbox"/> discharged from hospital/not available</p> <p style="margin-left: 20px;"><input type="checkbox"/> result not available</p> <p style="margin-left: 20px;"><input type="checkbox"/> other _____</p>	<p><b>1B. Results disclosed to:</b></p> <p><input type="checkbox"/> Patient</p> <p><input type="checkbox"/> Proxy</p> <p><input type="checkbox"/> Other _____</p> <p><b>1C. SP counselor intervention in case SP is a no-show or not available (indicate date):</b></p> <p><input type="checkbox"/> Phone patient ____/____/____</p> <p><input type="checkbox"/> Letter sent ____/____/____</p> <p><input type="checkbox"/> Other _____</p>
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### SOURCE PATIENT TEST RESULTS

Test	Positive		Negative		Indeterminate		Not Tested	Date
	Known	Tested	Known	Tested	Known	Tested		
HBsAg								
(HBeAg)							NA	
HBsAb								
HBcAb-IgM								
HBcAb-Tot								
HCV								
(HCV PCR)								
HIV								

Source patient not tested: (Why?) \_\_\_\_\_

#### LIVER FUNCTION TESTS (optional)

Test	Result	Date	Result	Date
AST				
ALT				
Total bilirubin				

### FOR HIV INFECTED SOURCE

<p><b>1. Stage of disease:</b></p> <p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Symptomatic HIV infection</p> <p><input type="checkbox"/> Asymptomatic HIV infection, not AIDS</p> <p><input type="checkbox"/> Unknown</p>	<p><b>2. Anti-retroviral therapy?</b></p> <p><input type="checkbox"/> Yes</p> <p style="margin-left: 20px;"><i>Indicate drugs taken, doses, dates in table below</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>									
<b>Drug taken</b>	<b>AZT</b>	<b>3TC</b>	<b>IND</b>	<b>NEL</b>	<b>ddI</b>	<b>d4T</b>				
Currently										
Recently										
Ever										
Dose										
<p><b>3A. Current total CD4 count:</b> _____</p> <p><b>Date:</b> ____/____/____</p> <p>(Current=6 months before exp date/present)</p>					<p><b>3B. Old total CD4 count:</b> _____</p> <p><b>Date:</b> ____/____/____</p> <p>(Old= more than 6 months ago)</p>					
<p><b>4A. Current viral load</b> _____ <b>copies/ml</b></p> <p><b>Current date:</b> ____/____/____</p>					<p><b>4B. Old viral load</b> _____ <b>copies/ml</b></p> <p><b>Old date:</b> ____/____/____</p>					