SOURCE PATIENT RISK ASSESSMENT

SOURCE PATIENT KNOWN POSITIVE:

❑ YES ❑ NO ❑ UNKNOWN

If yes, please specify:

_____

_____

_____

HIV Viral Load if known _____

OTHER KNOWN RISK FACTORS FROM SOURCE

_____ Blood Transfusions (prior to 1992)
_____ History of High Risk Sexual Behavior
_____ Previous or Current Injectable Drug Use
_____ Other (SPECIFY)

ACTIONS TAKEN AS A RESULT OF EXPOSURE

GUIDELINES REVIEWED ❑ YES ❑ NO

SITE OF INITIAL ASSESSMENT AND CARE ❑ NONE

SELF CARE ADMINISTERED (SPECIFY) ❑ NONE

POST-EXPOSURE TREATMENT

❑ NO TREATMENT RECOMMENDED

❑ TREATMENT RECOMMENDED (SPECIFY)

❑ TREATMENT RECEIVED (SPECIFY) DATE TREATMENT INITIATED _____

FOLLOW UP NEEDED?

❑ NO

❑ YES (SPECIFY)

FOLLOW UP DATE _____ FOLLOW UP LOCATION _____

BY SIGNING BELOW, I INDICATE THAT I UNDERSTAND THIS FORM WILL BE KEPT CONFIDENTIAL. I ALSO UNDERSTAND THAT ADMINSTRATORS (OR THEIR DESIGNEES) FROM MY COLLEGE/DEPARTMENT OR PROGRAM, THE OFFICE OF THE UNIVERSITY PHYSICIAN, AND THE OCCUPATIONAL HEALTH SERVICE WILL ALSO REVIEW THIS FORM.

STUDENT SIGNATURE _____ (print) | _____ (signature) DATE: _____

PREPARER'S SIGNATURE _____ (print) | _____ (signature) DATE: _____

COLLEGE / DEPT / PROGRAM ADMINISTRATOR: _____ (print) | _____ (signature) DATE: _____

RETURN COMPLETED FORM TO THE ADDRESS OR FAX NUMBER BELOW

Occupational Health Nurse • MSU Occupational Health Srvc • Olin Health Center • East Lansing, MI 48824-1037 • 517.355.0332

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