

FAX – Medical Confidential



Office of the Chief Medical Officer of Health

Determination of Significance of Blood and/or Bodily Fluid Exposure under the Mandatory Testing and Disclosure Act

Instructions: Reporting physician – please complete and fax this form to Alberta Health and Wellness for applications under the Mandatory Testing and Disclosure Act. Please keep original of the completed form on applicant’s chart.

Date of fax: _____ YYY Y / MM / DD	Re: Mandatory Testing and Disclosure Act – Determination of Significance
To: Chief Medical Officer of Health	From: _____ <i>Name of Reporting Physician</i> _____ <i>RHA</i>
Fax: (780) 422 9743	Phone: _____ _____ <i>Physician phone number</i>
Phone: (780) 427 5263	
	Pages: (including cover)

The contents of this transmission are intended for the use of the addressee only and may contain information that is privileged and confidential. If you are not the intended recipient, please be advised that any dissemination, distribution or copying of the content of this fax is strictly prohibited. If you have received this fax in error, or if you have trouble receiving this fax, please notify us immediately by calling the number noted above

Please keep original on applicant’s chart

Determination of Significance of Blood and/or Bodily Fluid Exposure under the Mandatory Testing and Disclosure Act

A. Applicant (recipient of exposure) information

				Alberta personal health number	
Name		Last	First	Middle	
Address		City/town	Province	Postal code	
Phone number	Alternate phone number	Date of birth		Age	<input type="checkbox"/> Female <input type="checkbox"/> Male

Family physician's name (if different from Reporting Physician)		
Office address	City/town	Province
		Postal code
Office phone number	Office fax number	

B. History of exposure

Date of exposure _____ **Time of exposure** _____ (24 hour)

Type of exposure (check all that apply)

- Percutaneous injury (specify) →
 - needlestick-hollow bore needle
 - needlestick-solid needle
 - cut by sharp object
 - other (specify) _____
- Bite which breaks the skin
- Other (specify) _____
- Contact with applicant's non-intact skin (specify) →
 - cut skin
 - chapped/abraded skin
- Contact with applicant's mucous membranes (specify) →

Type of bodily fluid/substance contacted by the applicant (check all that apply)

- Blood/serum/plasma
- Other bodily fluid/substance (specify) _____
- Biologic fluid/substance visibly contaminated with blood (specify) →
 - tears
 - urine
 - nasal secretions
 - feces
 - sputum
 - saliva
 - vomitus
 - other (specify) _____

Description of circumstances surrounding the exposure **(as provided by applicant)**

C. Examination of applicant

Findings related to the exposure including assessment of injuries, if any (e.g. depth/type of injury)

D. History of immunization and serostatus of applicant

Immunization history of applicant	Unknown	No	Yes	Date (if applicable)
Received hepatitis B vaccine – dose 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Received hepatitis B vaccine – dose 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Received hepatitis B vaccine – dose 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Serostatus history of applicant	Unknown	No	Yes	Serostatus result (if applicable)	Date (if applicable)
Hepatitis B carrier (HBsAg positive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis B immune (anti-HBs positive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HCV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

E. Information on source of blood and/or bodily fluid (check all that apply)

injection drug user
 Source risk factors unknown
 History of incarceration
 Other risk factors (specify) _____

F. Baseline testing of applicant

- **mandatory for application to proceed unless applicant known to be positive**
- mark baseline testing requisition "STAT"
- copy of baseline testing results must be sent to applicant's family physician named in Section A.

	Refused by applicant	Serostatus result	Date
Hepatitis B surface antigen (HBsAg)	<input type="checkbox"/>	_____	_____
Hepatitis B surface antibody (anti-HBs)	<input type="checkbox"/>	_____	_____
Hepatitis C antibody	<input type="checkbox"/>	_____	_____
HIV antibody	<input type="checkbox"/>	_____	_____

G. Post-exposure prophylaxis of applicant

	Refused by applicant	Not applicable	Date initiated/administered
Hepatitis B vaccine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B immune globulin (HBIG)	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV post-exposure prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	_____

H. Counselling

Applicant has been counselled as outlined in MDTA protocol

Yes
 No (specify reason) _____
 Refused by applicant

I. Referral of applicant for follow-up

Follow-up physician's name			
Office address	City/town	Province	Postal code
Office phone number	Office fax number		

J. Assessment of significance of exposure (as defined in MDTA protocol)

- Significant exposure
 Non-significant exposure

Comments:

_____ Reporting physician's name (please PRINT)
 _____ Signature of reporting physician
 _____ Date