TANNER HEALTH SYSTEM
SCHOOL OF NURSING

Post-Exposure Counseling Checklist

Name _____ Social Security Number _____

Date of exposure _____ Clinical site _____

I have read and understand the information provided by the clinical facility regarding recommendations for evaluation and treatment following clinical exposure to blood or body fluids. The risks and benefits of HBV, HCV, and HIV testing and prophylaxis have been explained to me.

1. _____ I want my blood tested for HBV.
2. _____ I do not want my blood tested for HBV.
3. _____ I want my blood tested for HCV.
4. _____ I do not want my blood tested for HCV.
5. _____ I want my blood tested for HIV (agency must provide HIV counseling and obtain written consent before blood may be drawn).
6. _____ I do not want my blood tested for HIV.
7. _____ I want to have a sample of my blood drawn and stored for 90 days, but not tested at this time. I understand that I may request HBV, HCV, and/or HIV testing of this blood sample at any time within 90 days.
8. _____ I have been offered and accepted HBV prophylaxis.
9. _____ I have been offered and do not want HBV prophylaxis.
10. _____ I have been offered and accepted HIV prophylaxis (**women**: To the best of my knowledge, I am not currently pregnant).
11. _____ I have been offered and do not want HIV prophylaxis.

To prevent the possible transmission of HBV, HCV, and HIV, I agree to abstain from sexual relations, or if I choose to have sexual relations, to inform my partner of my possible exposure

and use barrier precautions (latex condom with spermicide) until I know the results of the 6 month follow-up. I will not donate blood semen or organs until completion of the follow-up period. (**Women**: I agree to avoid pregnancy for a minimum of 6 months. If currently breast-feeding, I will cease for a minimum of 6 months).

I accept responsibility for all fees associated with postexposure testing and prophylaxis. I understand that extended postexposure testing and prophylaxis may be completed at the UWG Health Center or a personal health care provider of my choice. I understand that I should report any acute illness causing fever, rash, lymphadenopathy, persistent cough, or diarrhea within the next 3 months to my health care provider. If participating in the HBV and/or HIV prophylaxis, I agree to adhere to the monitoring requirements.

I understand that the results of my testing will remain confidential. I will not disclose the name and infectious status of the source patient.

_____ _____

UWG Student Signature Date

_____ _____

UWG Faculty Signature Date