Occupational Health Department , Cork University Hospital, Wilton, Cork

HIV PEP PRESCRIPTION CHECKLIST

To be completed by doctor assessing the blood/body fluid exposure:

Part 1: Recipient involved

Full Name: ____ (In capitals)

Address: ____

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Work Address: ____

Home Telephone No: _____________________**Mobile Phone No:** _____________________

Date of Birth: _ _ / _ _ / _ _ **Gender: M** ☐ **F** ☐

Occupation: ____

Hospital/Area: ______________________**Department/Ward**: ______________________

Part 2:

	Yes	No	Comments
Is recipient pregnant?			
Is recipient trying to conceive?			
Is recipient breastfeeding?			
Does the recipient have any underlying medical problems?			
Is the recipient taking any medication?			

Part 3: Action taken

	Yes	No	Comments
Have blood samples been taken from recipient for , HIV Ag/Ab, HBsAg, anti-HBc, anti-HCV, FBC, LFT, U & E, Bone profile, urinalysis (for proteinuria) & pregnancy test (urine strip)?			
Has recipient been advised to use condoms during sexual intercourse?			
Has recipient been informed that he/she can continue working normally?			

Doctor's signature: _______________________________________ **Date**: _ _ / _ _ / _ _

(Please tick the appropriate box) **I do wish to accept PEP** ☐ **I do not wish to accept PEP** ☐

Recipient's signature: _______________________________________ **Date**: _ _ / _ _ / _ _

Appendix xi