FAX – Medical Confidential

Alberta Health and Wellness

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:	_____/_____/_____ *YYYY MM DD*	Re:	**Mandatory Testing and Disclosure Act – Determination of Significance**
To:	**Chief Medical Officer of Health**	From:	_____ *Name of Reporting Physician* _____ *RHA*
Fax:	780-427-7683	Phone:	_____ *Physician phone number*
Phone:	780-427-5263		
		Pages: (including cover)	

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Please keep original on applicant's chart

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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**	☐ **Female** ☐ **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
- ☐ feces
- ☐ vomitus
- ☐ urine
- ☐ sputum
- ☐ other (specify)_____
- ☐ nasal secretions
- ☐ saliva

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	☐	☐	☐	_____
Received hepatitis B vaccine – dose 2	☐	☐	☐	_____
Received hepatitis B vaccine – dose 3	☐	☐	☐	_____

Serostatus history of applicant	**Unknown**	**No**	**Yes**	**Serostatus result** (if applicable)	**Date** (if applicable)
Hepatitis B carrier (HBsAg positive)	☐	☐	☐	_____	_____
Hepatitis B immune (anti-HBs positive)	☐	☐	☐	_____	_____
HCV positive	☐	☐	☐	_____	_____
HIV positive	☐	☐	☐	_____	_____

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)	☐	_____	_____
Hepatitis B surface antibody (anti-HBs)	☐	_____	_____
Hepatitis C antibody	☐	_____	_____
HIV antibody	☐	_____	_____

G. Post-exposure prophylaxis of applicant

	Refused by applicant	**Not applicable**	**Date initiated/administered**
Hepatitis B vaccine	☐	☐	_____
Hepatitis B immune globulin (HBIG)	☐	☐	_____
HIV post-exposure prophylaxis	☐	☐	_____

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 MTDA protocol)

☐ Significant exposure ☐ Non-signifiant exposure

Comments:

_____

_____

_____ _____ _____

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