GEORGIA DEPARTMENT OF PUBLIC HEALTH

HIV Post-Exposure Prophylaxis (PEP)

Patient Intake Form

(CONFIDENTIAL-PROTECTED HEALTH INFORMATION)

Today's Date _____/_____/_____

PATIENT INFORMATION:

Name:_____ Birth Date _____/_____/_____ Age:_____

Visit Date _____/_____/_____ Address: _____

Phone: ( ) _____ Email Address_____

Primary Care Provider: _____

Do you have health insurance? ☐ Yes / ☐ No
Insurance Provider Name _____

Are you 14 years of age or older, if yes then continue. If not, please stop and consult with the pharmacist.	□ Yes □ No
Have you ever been diagnosed with Human Immunodeficiency Virus (HIV)? If yes, then stop and consult with pharmacist.	□ Yes □ No

In the last 3 days (72 hours) have you experienced any of the following:

High-Risk • Intercourse (receptive or insertive) with a person known to be HIV positive • Needle sharing with a person known to be HIV positive • Injuries with exposure to potentially infectious fluids (through eye, mucous membrane, percutaneous, or non-intact skin) of a person known to be HIV positive	□ Yes □ No
Lower-Risk • Intercourse (receptive or insertive) with a person with an unknown HIV status • Mouth to vagina, penis, or anus contact (insertive or receptive) with a person known to be HIV positive • Injuries with exposure to potentially infectious fluids (through eye, mucous membrane, percutaneous, or non-intact skin) of a person with unknown HIV status	□ Yes □ No

Estimated time of potential exposure: ___:_____AM/PM _____/_____/_____

MEDICAL HISTORY:

Patient may opt out of providing their medical history, and this will not prohibit treatment

Are you able to become pregnant?	□ Yes □ No
Are you currently pregnant?	□ Yes □ No
Are you currently breast-feeding?	□ Yes □ No
Have you ever been diagnosed with kidney disease or told by a medical provider that you have decreased kidney function?	□ Yes □ No
Please list all of your current medications, including nonprescription medications and dietary supplements: _____ _____	
Have you ever taken HIV post-exposure prophylaxis (PEP) in the past?	□ Yes □ No
If you answered yes to the previous question, what date did you have this medication? And did you have any side effects or serious problems? Date: _____/_____/_____ If yes, please explain: _____ _____ _____	□ Yes □ No

Patient Consent to Treat

By signing this document, I agree to:

- Seek HIV testing, if not already done
- Seek follow-up care with a medical provider; and

Signature: _____ Date: _____/_____/_____

Patient Consent to Release of Information

- Allow the pharmacist/pharmacy to release information about my care today to my primary provider or the medical provider of my choosing.

Signature: _____ Date: _____/_____/_____

(refusal to sign does not prevent you from receiving PEP)

We protect lives.