Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
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Follow-up Laboratory Testing

*required for saving **required for completion

Facility ID#: _____ Lab #: _____

*HCW ID#: _____

HCW Name, Last: _____ First: _____ Middle: _____

*Gender: ☐ F ☐ M ☐ Other *Date of Birth: ____ /____ /_____

**Exposure Event #: _____

Lab Results **Lab test and test date are required.**

	Serologic Test	Date	Result
HIV	HIV EIA	__/__/____	P N I R
	Confirmatory	__/__/____	P N I R
HCV	anti-HCV-EIA	__/__/____	P N I R
	anti-HCV-supp	__/__/____	P N I R
	PCR HVC RNA	__/__/____	P N R
HBV	HBs Ag	__/__/____	P N R
	IgM anti-HBc	__/__/____	P N R
	Total anti-HBc	__/__/____	P N R
	Anti-HBs	__/__/____	___ mIU/mL

Other Labs	Other Test	Date	Value
	ALT	__/__/____	____ IU/L
	Amylase	__/__/____	____ IU/L
	Blood glucose	__/__/____	____ mmol/L
	Hematocrit	__/__/____	____ %
	Hemoglobin	__/__/____	____ gm/L
	Platelet	__/__/____	____ $x10^9$/L
	# Blood cells in urine	__/__/____	____ #/mm^3
	WBC	__/__/____	____ $x10^9$/L
	Creatinine	__/__/____	____ µmol/L
	Other: _____	__/__/____	_____

Result Codes: P=Positive N=Negative I=Indeterminate R=Refused

Custom Fields

Label		Label	
_____	____/____/_____	_____	____/____/_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments