Ontario

Ministry of Health

Form 1 - Physician/Nurse Practitioner Report

Pursuant to the Mandatory Blood Testing Act, 2006 and O. Reg. 449/07

To be completed by the Reporting Physician or Nurse Practitioner

Note to Physician or Nurse Practitioner:

If the applicant submits an application under section 2 of the *Mandatory Blood Testing Act, 2006* to the Medical Officer of Health of the local public health unit where the respondent* lives that meets the requirement of the regulations, the application, including this Physician/Nurse Practitioner Report will be referred to the Consent and Capacity Board.

*"For purpose of the *Mandatory Blood Testing Act, 2006*, the respondent means the person who the applicant identifies as a person with whose bodily substance the applicant came into contact."

The applicant must consent to counselling, including counselling respecting prophylaxis or treatment. Otherwise, the application shall not proceed.

Please complete all sections of this Report. Once completed, please provide this Physician/Nurse Practitioner Report to the applicant.

Fields marked with an asterisk (*) are mandatory.

A. Applicant Information

Collection of the information on this form is for the determination of an application under the *Mandatory Blood Testing Act, 2006*, for an order requiring a respondent to give a blood sample to determine the presence of a listed communicable disease. The authority for collection and use of this information is the *Mandatory Blood Testing Act, 2006*.

Last Name *	First Name *	Middle Initial

OHIP Number (10 digits) *	Version *	Date of Birth (yyyy/mm/dd) *	Age *

Current Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *

Telephone Number *	Fax (if applicable)	Email Address (if applicable)

Primary Care Provider Information

Is Primary Care Provider (Family Physician/Nurse Practitioner) same as Reporting Physician/Nurse Practitioner ? *

☐ Yes ☐ No

If Primary Care Provider (Family Physician/Nurse Practitioner) different from Reporting Physician/Nurse Practitioner complete the following:

Last Name *	First Name *	Middle Initial

Office Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *

Telephone Number *	Fax (if applicable)	Email Address (if applicable)

B. Reporting Physician/Nurse Practitioner Information

Physician's or Nurse Practitioner's Name

Last Name *	First Name *	Middle Initial

Office Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *

Telephone Number *	Fax (if applicable)	Email Address (if applicable)

C. History of Exposure - as reported by the applicant

Date of Exposure * Time of Exposure * : a.m. p.m.

Type of exposure the applicant experienced *

- Percutaneous injury (e.g., needle stick or cut by sharp object)
- Bite which breaks the skin
- Contact with applicant's non-intact skin (e.g., cut, chapped or abraded skin)
- Contact with applicant's vagina or anus
- Contact with applicant's mucous membrane (eyes, nose, mouth)
- Other/Specify: _____

Type of bodily substance with which the applicant had contact *

- Blood, Plasma or Serum
  - Please select if you know
    - Blood Plasma Serum
- Any biologic fluid/substance visibly contaminated with blood
  - Please select if you know
    - Tears Nasal Secretions Sputum Vomitus Urine Feces
- Fluid or Tissues
  - Please select if you know
    - Pleural Pericardial Peritoneal Synovial Amniotic Fluid Cerebro-spinal Fluid Tissues
- Secretions or Semen
  - Please select if you know
    - Uterine/vaginal secretions Semen
- Saliva
- Other/Specify: _____

Description of circumstances surrounding the occurrence as explained by applicant *

D. Examinations

Findings of examinations related to the occurrence including assessment of injuries sustained (if any)

E. Immunization History / Serostatus of Applicant *

Immunization/Serostatus	Yes	Date (if applicable)	Serostatus Results (if applicable)	No	Unknown
Received Hepatitis B vaccine	☐			☐	☐
Known to be a carrier - HBs Ag positive	☐			☐	☐
Known to be immune - Anti–HBs positive	☐			☐	☐
Known to be HCV positive	☐			☐	☐
Known to be HIV positive	☐			☐	☐

F. Base Line Testing – Consent is mandatory for application to proceed unless physician/nurse practitioner has satisfactory evidence of seropositivity *

Note to Physician/Nurse Practitioner:

Applicant’s base line testing requisition is to be marked "**STAT**".

A copy of the applicant’s base line testing results should be sent to the applicant’s family physician/nurse practitioner (if known) and the reporting physician/nurse practitioner named in section B above.

Test	Yes	Date Ordered	Refused by Applicant	Not Applicable (N/A)
Anti HBc	☐		☐	☐
Hepatitis B surface antigen (HbsAg)	☐		☐	☐
Anti HBs	☐		☐	☐
Anti HCV	☐		☐	☐
Antibody to HIV	☐		☐	☐

G. Post-exposure Prophylaxis and Treatment *

Test	Yes	Date Commenced	Refused by Applicant
Hep B Vaccine	☐		☐
Hep B Immune Globulin (HBIG)	☐		☐
Post–exposure prophylaxis for HIV	☐		☐

H. Counselling Relevant to the Occurrence

The applicant has consented to counselling respecting the occurrence, including post-exposure prophylaxis and treatment. *

☐ Yes ☐ No (counselling refused by applicant)

Counselling Physician/Nurse Practitioner is the same as Primary Care Provider

☐ Yes ☐ No

Reporting Physician/Nurse Practitioner

☐ Yes ☐ No

If Counselling Physician/Nurse Practitioner is not the same as either Primary Care Provider (Family Physician or Nurse Practitioner) or Reporting Physician/Nurse Practitioner, complete the following: *

Physician's or Nurse Practitioner's Name

Last Name *	First Name *	Middle Initial

Office Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *

Telephone Number *	Fax (if applicable)	Email Address (if applicable)

I. Assessment of Reporting Physician/Nurse Practitioner

As a physician/nurse practitioner qualified to make a physician/nurse practitioner report under the *Mandatory Blood Testing Act, 2006* and based on information provided to me by the applicant and after referencing the most recent publication protocols, such as the OHA/OMA Communicable Disease Surveillance Protocols for Ontario Hospitals - Blood-borne Diseases (Revised November 2018), my assessment of the applicant's risk of exposure to HIV/AIDS, Hepatitis B and/or Hepatitis C is: *

☐ Potentially Significant ☐ Non-significant ☐ Indeterminate

Physician's or Nurse Practitioner's Name

Last Name *	First Name *	Middle Initial

Signature *	Date (yyyy/mm/dd) *

Save Form Print Form Clear Form

For Office Use Only

Unique File Identifier	Unique File Number