

Form 1 - Physician Report

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

TO BE COMPLETED BY THE REPORTING PHYSICIAN

Note to Physician:

If the applicant submits an application under the *Mandatory Blood Testing Act, 2006* the information contained in this form will be disclosed to the medical officer of health and if there is a hearing, the Consent and Capacity Board.

***The respondent is the person whose bodily substances the applicant may have come into contact with.**

The applicant must consent to examination, counselling, including counselling respecting prophylaxis or treatment, and base line testing for HIV/AIDS, hepatitis B and hepatitis C. Otherwise, the application shall not proceed.

The application may still proceed if the applicant refuses to consent to prophylaxis or treatment.

You must order base line testing for the applicant in accordance with this form's instructions. You are not required to order base line testing for a listed communicable disease if you have other evidence of the applicant's seropositivity respecting that disease.

The applicant must provide one copy of this form, together with a completed applicant report, to the medical officer of health in the appropriate health unit no **more than seven days** after he or she came into contact with the bodily substance of the respondent. Otherwise, the application is invalid and shall not proceed under the *Mandatory Blood Testing Act, 2006*.

Once completed, please give two copies of this physician report to the applicant and retain one copy for your records.

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 HIV/AIDS, hepatitis B and/or hepatitis C status of the respondent. The authority for collection and use of this information is the *Mandatory Blood Testing Act, 2006*. For information about collection practices contact the Corrections and Community Safety Policy Branch, Ministry of Community Safety and Correctional Services at 416 325-7331.

Last Name			First Name			Middle Initial		
Address								
Unit Number		Street Number		Street Name				
City/Town			Province Ontario	Postal Code	Home Telephone ()		Business Telephone ()	
OHIP Number (10 digits)			Version	Sex	Age		Date of Birth (yyyy/mm/dd)	
				<input type="checkbox"/> Male <input type="checkbox"/> Female				
Family Physician - if Different from Reporting Physician								
Last Name			First Name			Middle Initial		
Unit Number		Street Number		Street Name				
City/Town			Province Ontario	Postal Code	Office Telephone ()		Office Fax Number ()	

B. Reporting Physician Information

Physician's Name - Please Print or Use Physician's Stamp

Last Name			First Name			Middle Initial		
Office Address								
Unit Number		Street Number		Street Name				
City/Town			Province Ontario	Postal Code	Office Telephone ()		Office Fax Number ()	

C. History of Exposure - As reported by the applicant

Date of Exposure (yyyy/mm/dd)

Time of Exposure am
 pm

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, serum, plasma - *please circle if known.*
- Any biologic fluid/substance visibly contaminated with blood (tears, nasal secretions, sputum, vomitus, urine or faeces) - *please circle if known.*
- Pleural, pericardial, peritoneal, synovial, amniotic or cerebro-spinal fluid or tissues - *please circle if known.*

- Uterine/vaginal secretions or semen
- Saliva

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	<input type="checkbox"/>	yyyy/mm/dd		<input type="checkbox"/>	<input type="checkbox"/>
Known to be a carrier - HBs Ag positive	<input type="checkbox"/>	yyyy/mm/dd		<input type="checkbox"/>	<input type="checkbox"/>
Known to be immune - Anti-HBs positive	<input type="checkbox"/>	yyyy/mm/dd		<input type="checkbox"/>	<input type="checkbox"/>
Known to be HCV positive	<input type="checkbox"/>	yyyy/mm/dd		<input type="checkbox"/>	<input type="checkbox"/>
Known to be HIV positive	<input type="checkbox"/>	yyyy/mm/dd		<input type="checkbox"/>	<input type="checkbox"/>

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

Note to Physician:

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

A copy of the applicant's base line testing results must be sent to the applicant's family physician (if known) and the reporting physician named in section B above.

	Yes	Date Ordered	Refused by Applicant
Anti HBc	<input type="checkbox"/>	yyyy/mm/dd	
Hepatitis B surface antigen (HbsAg)	<input type="checkbox"/>	yyyy/mm/dd	
Anti HBs	<input type="checkbox"/>	yyyy/mm/dd	
Anti HCV	<input type="checkbox"/>	yyyy/mm/dd	
Antibody to HIV	<input type="checkbox"/>	yyyy/mm/dd	

G. Post-exposure Prophylaxis and Treatment

	Yes	Date Commenced	N/A	Refused by Applicant
Hep B Vaccine	<input type="checkbox"/>	yyyy/mm/dd	<input type="checkbox"/>	
Hep B Immune Globulin (HBIG)	<input type="checkbox"/>	yyyy/mm/dd	<input type="checkbox"/>	
Post-exposure prophylaxis for HIV	<input type="checkbox"/>	yyyy/mm/dd	<input type="checkbox"/>	

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)

I. Referral for Post-Exposure Follow-up and Care - If applicable

Physician's Name - Please Print or Use Physician's Stamp

Last Name	First Name	Middle Initial
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Office Address

Unit Number	Street Number	Street Name
City/Town	Province Ontario	Postal Code
		Office Telephone ()
		Office Fax Number ()

J. Assessment of Reporting Physician

As a physician qualified to make a physician 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 December 2002), 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 Name - Please Print

Last Name	First Name	Signature	Date (yyyy/mm/dd)
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