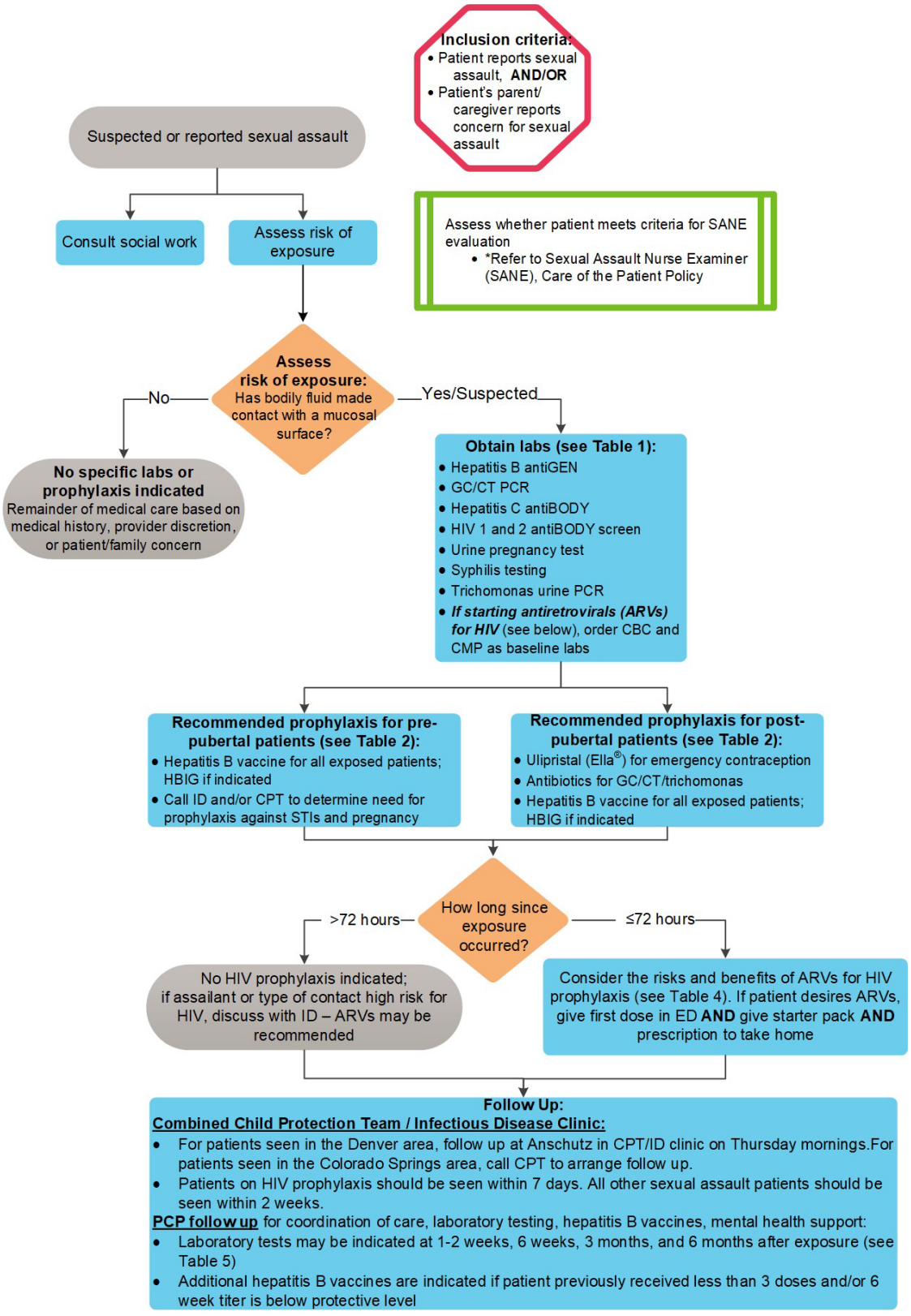
BLOOD OR BODILY FLUID EXPOSURE IN THE COMMUNITY (NON-OCCUPATIONAL)

ALGORITHM 1. Sexual Assault



ALGORITHM 2. Needle Stick or Other Bodily Fluid Exposure

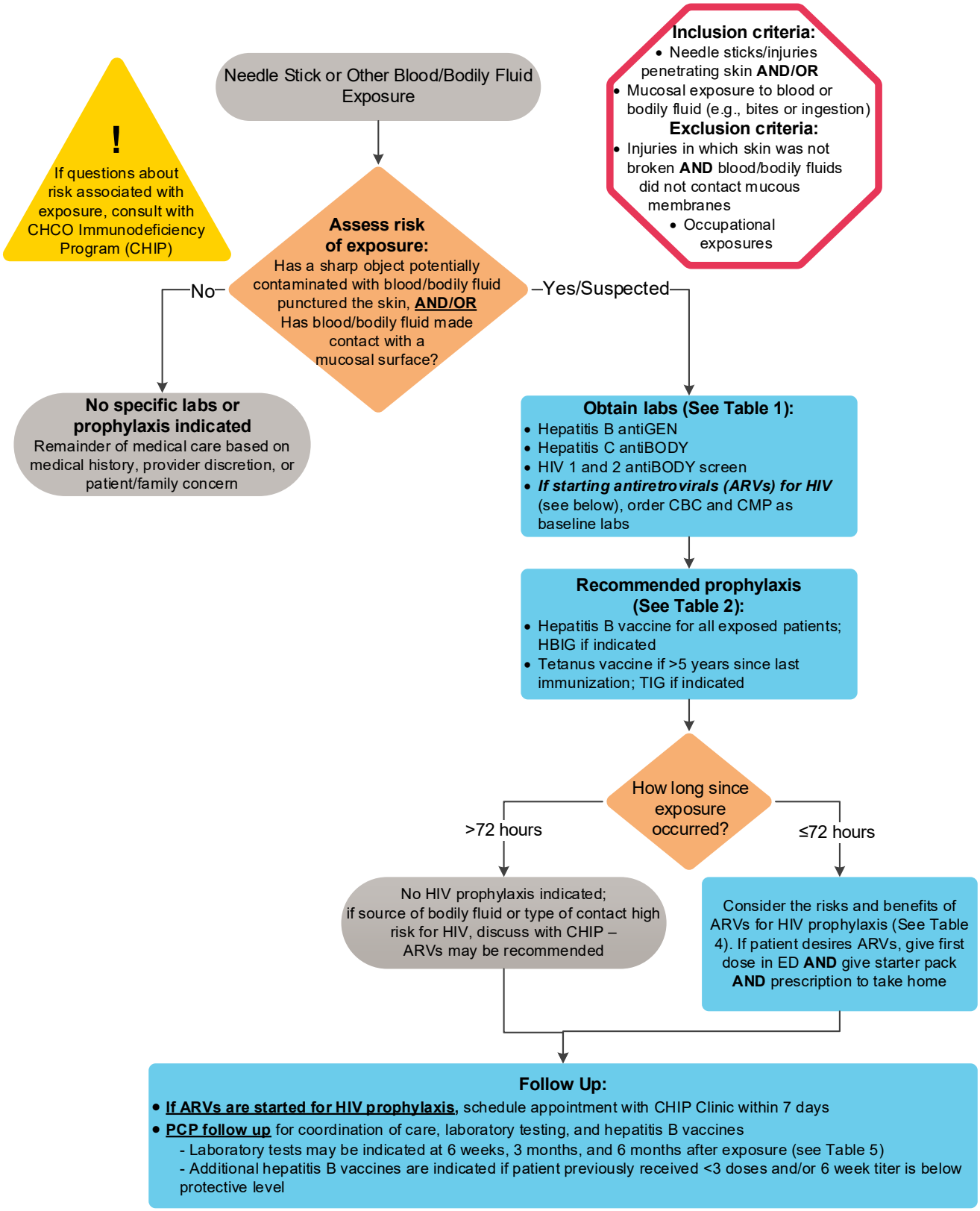


TABLE OF CONTENTS

TARGET POPULATION: SEXUAL ASSAULT

Inclusion Criteria

- Pediatric patients reporting sexual assault—defined as any forced or coerced sexual behavior that occurs without consent/assent, **AND/OR**
- Pediatric patients whose parents report concern for sexual assault

Exclusion Criteria

- Severe physical trauma necessitating emergent operation or repair (Must address trauma first, proceed with workup and prophylaxis once stable. Alert CPT and/or ID to pending need for workup and prophylaxis).

TARGET POPULATION: NEEDLE STICK INJURY / OTHER BLOOD OR BODILY FLUID EXPOSURE

Inclusion Criteria

- Needle sticks that penetrate the skin, due to discarded needles found in a community setting, **AND/OR**
- Other injuries that penetrate that skin, due to any sharp object contaminated with blood or bodily fluids, **AND/OR**
- Mucosal exposure to blood or bodily fluid, such as a bite injury, or ingestion of any material contaminated with blood or body fluid

Exclusion Criteria

- Any injury in which skin was not broken AND blood/bodily fluids did not contact mucous membranes
- Occupational needle sticks or other injuries or exposures that occur in a workplace setting (refer to Occupational Health Services)

BACKGROUND | DEFINITIONS

These clinical care recommendations are designed to help medical providers identify, screen, and treat children at-risk of transmission of infectious agents from blood or bodily fluid exposure in the community (including community needle sticks and sexual exposures).

Definitions

ARV: Antiretroviral drugs
CPT: Child Protection Team
CSH: Colorado Springs Hospital
HIV: Human Immunodeficiency Virus
ID: Infectious Diseases
PEP: Post-Exposure Prophylaxis
SANE: Sexual Assault Nurse Examiner
STI: Sexually Transmitted Infection

INITIAL EVALUATION: SEXUAL ASSAULT

Prior to evaluation of unconscious, intoxicated, or altered patients, consult with CPT.

History

- Details of exposure
  - Type of sexual contact
  - Mucosal surface(s) involved
  - Bodily fluid contact
- Patient factors
  - Pubertal status
  - Vaccination status for hepatitis B
- Assailant risk factors
  - Is the assailant known to be infected with HIV, hepatitis B, or hepatitis C?
  - Does the assailant agree to be tested for HIV, hepatitis B, or hepatitis C?

Physical Exam

- Perform a comprehensive physical exam, noting any injuries that could increase the risk of exposure
- Exam should be performed by a trained provider

INITIAL EVALUATION: NEEDLE STICKS AND OTHER EXPOSURES

History

- Details of exposure
  - In what setting was the contaminated object or material found?
  - If needle stick, was blood visible in the syringe? Was the sharp hollow bore or solid?
- Patient factors
  - Vaccination status for tetanus
  - Vaccination status for hepatitis B
- If the source of blood/body fluid is known:
  - Is the source known to be infected with HIV, hepatitis B, or hepatitis C?
  - Does the source agree to be tested for HIV, hepatitis B, or hepatitis C?
- If the source of blood/body fluid is unknown:
  - Blood from discarded needles should NOT be tested for viral infections.

Physical Exam

- Perform a comprehensive physical exam, noting any injuries
- Document the location and severity of any wounds that penetrated skin.

CLINICAL MANAGEMENT

Laboratory Studies

Labs indicated for: Patients with a blood or bodily fluid exposure of ANY TYPE, including sexual assault

- Hepatitis B AntiGEN – to rule out infection prior to current exposure. Hepatitis B antiBODY is not indicated, as Hepatitis B vaccination is recommended for all exposed patients, regardless of antibody titers[1]
- Hepatitis C AntiBODY – to rule out infection prior to current exposure
- HIV 1 and 2 AntiGEN and AntiBODY screen – to rule out infection prior to current exposure

Labs indicated for: MALES AND FEMALES with known or suspected oral, vaginal, penile, or anal sexual contact

- Gonorrhea/Chlamydia (GC/CT PCR from all sites of penetration/attempted penetration) – In females, urine can be sent in place of vaginal/cervical swab. Urine culture was previously gold standard, but PCR is sufficiently sensitive to make a diagnosis. Ensure that patient does not clean their genitals prior to collecting urine sample. Swabs can also be sent from swabs of the throat and/or rectum depending on sites exposed during assault.
- Syphilis screening
    - At Anschutz and Network of Care: send RPR (rapid plasma reagin)
    - At CSH: send Treponema antibody (LAB1197)

Labs indicated for: FEMALES with known or suspected vaginal sexual contact

- Urine Pregnancy Test – to determine whether patient was already pregnant at time of suspected assault, as it would be too early to diagnose new pregnancy
- Trichomonas Urine PCR – should be sent in place of vaginal pathogen screen

Labs indicated for: Patients who will be starting ARVs for HIV post-exposure prophylaxis

- Complete Blood Count (CBC) with differential – to provide a baseline; if patient is severely neutropenic, anemic, or thrombocytopenic, call ID.
- Comprehensive Metabolic Panel (CMP) – to provide a baseline; if renal function is abnormal or liver enzymes are elevated, call ID.

TABLE 1: Recommended Immediate Testing after Exposure

	ALL At-Risk Exposures					ADD IF Sexual Exposure				ADD IF Starting HIV PEP	
	Hep B Surface AntiGEN	Hep C Ab	HIV 1 and 2 Ag/Ab screen	HIV RNA PCR	Chemistry Hold serum + plasma	GC/CT PCR*	Syphilis test	Preg Test	Tricho-monas PCR	CBC with diff	CMP
Source# (If available)	X	X	X	X	X	X	X				
Exposed Patient	X	X	X		X	X	X	X	X	X	X

* Send samples from all sites of penetration/attempted penetration. Performance characteristics of the urine GC/CT PCR have not been established for children 13 years of age and younger.

"Source" is defined as the person whose blood or bodily fluids contacted the patient. In the case of sexual assault, "source" refers to the assailant. In the case of a needle stick, blood from a syringe should never be tested for infections.

Prophylaxis

Prophylaxis for patients with a blood or bodily fluid exposure of ANY TYPE, including sexual assault:

- HIV – consider PEP after discussion of risks/benefits (see pages 8-10)
- Hepatitis B – give vaccine to all exposed patients. Give Hep B Immune Globulin (HBIG) only if the exposed patient is unvaccinated, has received <3 doses of vaccine, or vaccination status is unknown, AND source is KNOWN TO BE INFECTED with hepatitis B[1,2].
- Hepatitis C – no prophylaxis is available.
- Tetanus – vaccine is indicated for needle stick or wound, if most recent tetanus vaccine was >5 years ago. Give Tetanus Immune Globulin (TIG) only if the exposed patient is unvaccinated, has received <3 doses of vaccine, or vaccination status is unknown[3].

Prophylaxis against STIs for post-pubertal MALES or FEMALES with known or suspected sexual exposure:

- Gonorrhea – all post-pubertal patients with sexual exposure (do not await results of PCR testing)
  - Weight ≤ 45 kg- Ceftriaxone IV/IM 250 mg once
  - Weight >45 - <150 kg- Ceftriaxone IV/IM 500 mg once
  - Weight ≥ 150 kg – Ceftriaxone IV/IM 1000mg once
  - If renal insufficiency, please contact ID for alternative
- Chlamydia – all post-pubertal patients with sexual exposure (do not await results of PCR testing) [PREFERRED REGIMEN][4]
  - Weight < 45 kg- Doxycycline 2mg/kg/dose PO BID x7 days (first dose given immediately)
  - Weight ≥ 45 kg- Doxycycline 100mg PO BID x7 days (first dose given immediately)
  - OR for patients who are unable to fill a prescription or complete a 7 day course of medication [POST TREATMENT EVALUATION/TESTING IS NEEDED DUE TO THE POSSIBILITY OF TREATMENT FAILURE][4]
    - Weight < 50 kg- Azithromycin 20 mg/kg PO once
    - Weight ≥ 50 kg- Azithromycin 1000 mg PO once

Prophylaxis against STIs and pregnancy for post-pubertal FEMALES with known or suspected sexual exposure:

- Trichomonas – post-pubertal patients who weigh ≥ 40 kg with positive trichomonas PCR. Note that tinidazole can cause nausea and vomiting; consider pre-medicating with ondansetron. Recent consumption of alcohol greatly increases the likelihood of nausea and vomiting.
  - Tinidazole 2000 mg PO once
- Pregnancy – female patients with negative pregnancy test, <120 hours since sexual contact
  - Ulipristal (Ella®) 30 mg PO once

Prophylaxis against STIs and pregnancy for pre-pubertal children with known or suspected sexual exposure:

- Call ID and/or CPT for all sexual assaults in pre-pubertal patients to determine the need for STI and/or pregnancy prophylaxis.
- If prophylaxis is not administered after discussion with ID and/or CPT, perform all screening labs and PCP should follow up on these labs and treat if necessary. Labs should be repeated at 1-2 weeks post exposure or sooner if symptomatic.

TABLE 2: Recommended Prophylaxis for Exposed Patients

Condition	Population Indicated			Prophylaxis
HIV	Patient/parent decision after discussion of risks/benefits (see pp. 8-10)			HIV PEP regimen PO x4 weeks
Hepatitis B	All exposed patients, even if fully vaccinated			Hep B vaccine
	Patients who are unvaccinated against Hep B, received <3 doses of Hep B vaccine, or vaccination status unknown	**AND**	Source is KNOWN TO BE INFECTED with Hep B	Hep B vaccine ***PLUS*** Hep B Immune Globulin (HBIG) 0.06 mL/kg IM
Hepatitis C	None			None
Tetanus	Needlestick/Wounds: more than 5 years since most recent tetanus vaccine			Tetanus vaccine only
	Needlestick/Wounds: unvaccinated or <3 doses tetanus vaccine			Tetanus vaccine ***PLUS*** Tetanus Immune Globulin (TIG) 250 Units IM
Gonorrhea*	Sexual Exposure, weight less than or equal to 45 kg			CefTRIAXone IV/IM 250 mg once
	Sexual Exposure, weight greater than 45 to less than 150 kg			CefTRIAXone IV/IM 500 mg once
	Sexual Exposure, weight greater than or equal to 150 kg			CefTRIAXone IV/IM 1000 mg once
Chlamydia*	Sexual Exposure, able to fill Rx, weight less than 45 kg			Doxycycline 2mg/kg/dose PO BID x7 days (first dose immediately)
	Sexual Exposure, able to fill Rx, weight greater than or equal to 45 kg			Doxycycline 100mg PO BID x7 days (first dose immediately)
	Sexual Exposure, UNABLE to fill Rx^, weight less than 50 kg			Azithromycin 20mg/kg/dose PO once
	Sexual Exposure, UNABLE to fill Rx^, weight greater than or equal to 50 kg			Azithromycin 1000 mg PO once
Trichomonas*	Sexual Exposure, positive trichomonas PCR, weight greater than or equal to 40 kg			Tinidazole PO 2000 mg once
Pregnancy	Sexual Exposure (within 120 hours), negative pregnancy test, patient choice			Ulipristal (Ella®) PO 30 mg once

*** For pre-pubertal patients, call ID and/or CPT to determine the need for prophylaxis.**
^Post treatment evaluation/testing is needed due to the possibility of treatment failure[4].

HIV Post-Exposure Prophylaxis (PEP)

The risk of HIV transmission varies greatly depending on the particular exposure. Given that each exposure is unique in its risk profile, a discussion of the risks of transmission, potential benefits of PEP, and potential complications of PEP with the patient/parents is recommended using the information provided below. Please call the on-call infectious diseases provider for help with PEP recommendations.

Potential Benefits of HIV Post-Exposure Prophylaxis

The potential benefit of HIV PEP depends on the efficacy of the regimen, timing of PEP initiation after exposure, and adherence to the entire regimen.

1. **Efficacy of Regimen**: PEP using single-drug therapy following occupational exposure decreases transmission by 81%[1]. Experts now recommend the use of a multi-drug regimen with more potent antiretroviral agents, which is likely to increase this efficacy.
2. **Timing of Exposure:** PEP is most effective when begun as soon as possible after exposure and becomes less effective as time from exposure increases. PEP is less likely to be effective 72 hours after exposure, but the interval after which no benefit is gained is unknown[1]. If >72 hours have passed since exposure to a source

whose HIV status is unknown, PEP is not recommended; however, testing per Table 1 should still be conducted. If >72 hours have passed since exposure to a source who is known to be HIV infected, please contact ID for recommendations on PEP.

3. **Adherence to PEP:** The efficacy of PEP depends upon adherence to the entire 28-day course of medication. The most common reason for PEP discontinuation is side effects. Although side effects of PEP regimens are common, they are rarely severe or serious (see Table 3 for regimen-specific side effects). The side effect profile of newer antiretrovirals is improved compared with older drugs.

PEP Drug Regimens

All regimens are FOUR WEEKS in duration. Prescribe 7 days of ondansetron (Zofran®) with every PEP regimen to ensure tolerability.

A. Weight ≥25 kg and can swallow pills:

Medication	Dose
Biktarvy ® **ADULT DOSE** (50mg bictegravir/200mg emtricitabine/25mg tenofovir alafenamide; BIC/FTC/TAF)*	1 tablet PO once daily

*Absorption is impaired by simultaneous administration of medications that contain polyvalent cations, such as antacids, laxatives, or multivitamins, UNLESS taken with food.

B. Weight ≥14 kg to <25 kg and can swallow pills:

Medication	Dose
Biktarvy ® **PEDIATRIC DOSE** (30mg bictegravir/120mg emtricitabine/15mg tenofovir alafenamide; BIC/FTC/TAF)*	1 tablet PO once daily

*Absorption is impaired by simultaneous administration of medications that contain polyvalent cations, such as antacids, laxatives, or multivitamins, UNLESS taken with food.

C. Weight <14 kg and/or cannot swallow pills. Prescribe ALL THREE DRUGS:

Medication	Strength	Weight	Dose (given BID)	Max dose
Lamivudine (3TC)	10 mg/ml liquid	<25 kg	4 mg/kg/dose	150 mg/dose
		≥25 kg	150 mg	
Zidovudine (AZT, ZDV)	10 mg/ml liquid	4-<9 kg	12 mg/kg/dose	300 mg/dose
		9-<30 kg	9mg/kg/dose	
		≥30 kg	300 mg	
Raltegravir (RAL)*	100mg chew tab dissolved in 5 mL water#	4-<6 kg	30 mg (1.5 ml)	300 mg/dose
		6-<8 kg	40 mg (2 ml)	
		8-<10 kg	60 mg (3 ml)	
		10-<14 kg	80 mg (4 ml)	
		14-<20 kg	100 mg (5 ml)	
	100 mg chew tab	20-<28 kg	150 mg	
		28-<40 kg	200 mg	
		≥40kg	300 mg	

* Absorption is impaired by simultaneous administration of medications that contain polyvalent cations, such as antacids, laxatives, or multivitamins, UNLESS taken with food.
# RAL chew tabs dissolve in water after ~15 minutes. The tablet should be fully dissolved before administration.

TABLE 3. Common Side Effects Experienced with the Recommended PEP Regimens

Intended patients	PEP regimen	Adverse Effects
Weight ≥14kg and can swallow pills	Biktarvy®	Common but mild: fatigue, dizziness, insomnia, headache, nausea, diarrhea, liver enzyme elevation. Rare but severe: muscle pain due to myositis.
Weight <14 kg and/or cannot swallow pills	Lamivudine / zidovudine / raltegravir	Common but mild: fatigue, dizziness, insomnia, headache, nausea, diarrhea, anemia, neutropenia, liver enzyme elevation, rash. Rare but severe: muscle pain due to myositis.

RISK OF TRANSMISSION

Risk of transmission of HIV or hepatitis B or C is based on the probability that the source was infected, the viral load of an infected source, and the type of exposure.

1. Probability source was infected:
    a. HIV: As of 2020, the Colorado Dept. of Public Health and Environment estimated that there were about 15,012 people in Colorado living with HIV[5]. This results in a prevalence of 0.26% (260 HIV-infected persons per 100,000 people). Certain risk groups, including injecting drug users and men who have sex with men, may have a higher seroprevalence. Seroprevalence also varies by county, with higher rates in Denver metro, Arapahoe and El Paso counties.
    b. Hepatitis B: The Colorado Dept. of Public Health and Environment does not track prevalence estimates for chronic hepatitis B virus infection in Colorado. However, a publication in 2020 estimated the prevalence of chronic HBV infection in the US as 0.71% (range of 0.51-1.02%)[6]. Applying this prevalence estimate to the 2020 Colorado population data results in an estimated total of 40,993 people living with chronic active HBV in Colorado (710 HBV-infected persons per 100,000 people). Certain risk groups, including incarcerated persons, injecting drug users, and persons experiencing homelessness, may have a higher seroprevalence.
    c. Hepatitis C: As of 2021, the Colorado Dept. of Public Health and Environment estimates thatthere are currently about 39,142 people in Colorado living with chronic, unresolved HCV[7]. This results in a prevalence of 0.68% (678 HCV-infected persons per 100,000 people).
2. Risk of HIV Transmission Based on Type of Exposure[1] –Table 4on the next page.

TABLE 4. Risk of HIV Transmission Based on Exposure Type

Exposure Type	Transmission Risk per Exposure to a Known HIV Positive Source	Comments
Exposure to Contaminated Sharp		
Accidental needle stick	0.23% *(1 per 435)*	• Discarded needles are low-risk exposures, as HIV is intolerant to environmental conditions. There has never been a reported case of HIV transmission from a discarded needle, as of 2022. • Risk of transmission from a needle stick depends on the bore of the needle and depth of penetration. • Discarded small bore needles (i.e. insulin syringes) or solid sharps (i.e. scalpels) with shallow penetration from a low-risk population (i.e. diabetics) would be of very low risk. • Newly discarded hollow bore needles with visible blood from areas frequented by high HIV seroprevalent populations (i.e. injecting drug users) would be of higher risk.
Needle-sharing during injection drug use	0.63% *(1 per 159)*	
Sexual Exposures		
Receptive anal intercourse	1.38% *(1 per 72)*	• Risk of HIV transmission due to sexual assault or abuse associated with trauma, bleeding, and tissue injury is significantly higher than that of consensual sexual contact. • The presence of other STIs, especially with genital ulcerations, also increases the risk of HIV transmission. • Although oral sex with intact mucosa is a low-risk transmission event, the presence of oral sores or mucosal injuries increases the risk of transmission. • Most experts would recommend PEP in cases of sexual assault or abuse, or sexual contact with a known HIV-positive source.
Receptive vaginal intercourse	0.08% *(1 per 1,250)*	
Insertive anal intercourse	0.11% *(1 per 909)*	
Insertive vaginal intercourse	0.04% *(1 per 2,500)*	
Oral sex with ejaculation	Low risk	
Mucous Membrane Exposures		
Oral exposure to blood	Negligible	• Biting: HIV transmission from bites is extremely rare. A bite without a break in the skin is not considered an exposure. A bite involving a high-risk source with breaks in the skin and blood exposure increases transmission risk. • Kissing/ Mouth to Mouth Resuscitation: Should not be considered an exposure without mucosal damage or blood exposure. • Saliva contaminated with blood poses a substantial exposure risk. HIV transmission by this route has been reported.
Non-intact Skin Exposures		• Rare cases of HIV transmission after non-intact skin exposure to infected blood have been documented, but the risk has not been quantified.

DISCHARGE PLANNING CHECKLIST

LABS

[ ] Obtain proper laboratory studies (see Table 1):

All Exposures	Sexual Exposure	Starting HIV PEP
[ ] Hep B Surface AntiGEN	[ ] GC/CT PCR	[ ] CBC with differential
[ ] Hep C Antibody	[ ] Syphilis test	[ ] CMP
[ ] HIV 1 and 2 Antibody Screen	[ ] Pregnancy Test	
	[ ] Trichomonas PCR	

PROPHYLAXIS

[ ] Provide prophylaxis for Hepatitis B, tetanus, GC/CT, trichomonas, and/or pregnancy as indicated in Table 2.

[ ] Discuss risks/benefits of HIV PEP (pp. 8-10). If starting PEP:

[ ] Enter order in Epic to obtain **PEP STARTER PACK** (Free 7-day supply of ARVs dispensed from Children's Hospital Colorado pharmacy, intended to bridge patient until follow-up in ID or CHIP clinic.) Patient should LEAVE THE ED WITH STARTER PACK in hand.

[ ] Give **FIRST DOSE** of ARVs in the Emergency Department with ondansetron (Zofran®) 4mg PO once.

[ ] Write a 7-day **PRESCRIPTION FOR ONDANSETRON** (Zofran®).

[ ] Write a 28-day **PRESCRIPTION FOR ARVs**. Instruct patient NOT TO FILL PRESCRIPTION unless directed by ID or CPT.

FOLLOW-UP

[ ] **Schedule follow up in ID and/or CPT clinics** via one of the following:

1) EPIC in-basket message (link in discharge SmartSet; preferred method)
2) Fax the PEP Follow-Up Request Form to 720-777-7295 (see attached)
3) For victims/survivors of sexual assault seen at CSH, call CPT Colorado Springs at 719-305-6919 to schedule follow up. CPT will arrange in-person follow-up along with an ID provider.

Victims/survivors of sexual assault on HIV PEP should follow up WITHIN 7 DAYS. At Anschutz, a combined ID/CPT clinic for victims/survivors of sexual assault occurs EVERY THURSDAY beginning at 8:30am. At CSH, ID/CPT appointments will occur on an as-needed basis.
Victims/survivors of sexual assault NOT on HIV PEP should follow up within 2 weeks in CPT clinic.
Victims of needle sticks or other exposures on HIV PEP should follow up within 7 days in CHIP clinic. (If not on HIV PEP, these patients should follow up with PCP only; see guidance below.)

[ ] **Notify Social Work** of all cases of confirmed or suspected sexual assault. Consider SANE consult; discuss with charge RN.

[ ] **Contact Information:** Confirm preferred patient contact information, including **confidential contact number** if adolescent sexual assault. List both in Demographics section of chart and on PEP Follow-Up Request Form, if using.

[ ] Give copy of **PATIENT/PARENT EXPOSURE HANDOUT**.

[ ] **PCP Follow-Up** is important for coordination of care, follow-up laboratory testing, vaccines, and mental health support. Follow-up tasks include labs as per Table 5, and vaccines as follows:

- HPV vaccines should be administered according to the routine 3-dose series.
- Hepatitis B vaccines may be indicated to complete the 3-dose series (see CDC catch-up immunization schedule)[2]. Indications for additional Hepatitis B vaccines:
  - Patient determined to be unvaccinated/under vaccinated against hepatitis B prior to the exposure
  - Hepatitis B surface antibody at 6 weeks is below the protective level

TABLE 5: Recommended Follow-Up Labs

	ALL EXPOSURES				SEXUAL EXPOSURES		
	Hep B Surface AntiGEN	Hep B Surface AntiBODY	Hep C Ab	HIV 1 and 2 Ab screen	GC/CT PCR	RPR	Pregnancy Test
1-2 Weeks					X[a]		
6 Weeks		X[b]		X	X[c]	X	X[d]
3 Months			X	X		X	
6 Months	X[e]	X[e]					

[a] Perform GC/CT testing of all sites of penetration/attempted penetration if any of the following are true: 1) Prophylaxis was not given during initial encounter; 2) Doxycycline was prescribed for prophylaxis, but patient reports poor adherence; 3) Patient reports symptoms of a STI at follow up.

[b] If the 6-week Hep B surface antibody is adequate, no further testing for Hep B is indicated. If the 6-week antibody is below the protective level, administer 2 additional Hep B vaccines to complete the 3-dose series and obtain Hep B testing at 6 months.

[c] Perform GC/CT testing of all sites of penetration/attempted penetration if a previous GC/CT PCR was positive AND any of the following are true: 1) Patient is pregnant; 2) Doxycycline was prescribed for treatment of chlamydia, but patient reports poor adherence; 3) Patient reports symptoms of a STI at follow up; 4) Reinfection is suspected after completing treatment.

[d] Only if did NOT receive emergency contraception during initial visit.

[e] Only if 6 week Hep B Surface Antibody was inadequate and additional doses of Hep B vaccine were given.

COMMUNITY (NON-OCCUPATIONAL) BLOOD AND/OR BODILY FLUID EXPOSURE

Post-Exposure Prophylaxis Clinic Follow-Up Request:

FAX TO: 720-777-7295

This form required ONLY if ID or CPT teams were NOT notified by EPIC in-basket message

Patient Name (Last, First): _____
Date of Birth:_____**MR#**_____**Patient Weight:** _____
Patient Address: _____
Phone #:_____**(H)**_____**(C)**
Preferred Confidential Phone # (if adolescent sexual exposure):_____
Insurance:_____**Other ID #:** _____
Primary Care Physician:_____**PCP Phone Number:**_____
Exposure Date/Time:_____
Brief Description of Exposure:

HIV PEP:

PEP started? [ ] yes [ ] no
If yes, regimen prescribed:

Drug	Dose

First Dose Given in ED [ ] yes [ ] no
Starter Pack Given [ ] yes [ ] no
28-Day Prescription Given [ ] yes [ ] no

[ ] CBC/diff

WBC	
Hct	
Plts	

[ ] LFTs

AST	
ALT	
T bili	

[ ] BUN/Cr

BUN	
Cr	

Other **Lab Work/Prophylaxis:**

[ ] HIV Antibody [ ] positive [ ] negative [ ] pending
[ ] STD screen sent (sexual exposures)
[ ] Syphilis [ ] Chlamydia [ ] Gonorrhea [ ]Trichomonas
[ ] Prophylaxis given:

Drug	Dose/Duration

[ ] Pregnancy Screen (sexual exposures) [ ] positive [ ] negative
[ ] Emergency Contraception given [ ] yes [ ] no
[ ] Hepatitis Screen
Hep B AntiGEN [ ] positive [ ] negative [ ] pending Hep C AntiBODY [ ] positive [ ] negative [ ] pending Hepatitis B Vaccine given [ ] yes [ ] no
If SOURCE is KNOWN TO BE Hepatitis B positive:
Hepatitis B Immune Globulin given [ ] yes [ ] no
[ ] Tetanus Vaccine [ ] up-to-date [ ] vaccine given [ ] TIG given

Treating Provider Name:_____**Pager #:**_____

Date:_____ **Time:** _____

PATIENT | CAREGIVER EDUCATION

- Sexual Assault and Possible Exposure to Disease: For Teen
  - English
  - Spanish
- Sexual Assault and Possible Exposure to Disease: For Parent of Child
  - English
  - Spanish
- Needle Sticks and Other Exposure to Blood
  - English
  - Spanish

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7. Colorado Prevalence and Incidence of Hepatitis C Virus Infection: A Modeling Study (2018 update). A collaboration between the Colorado Department of Public Health and Environment and the Center for Disease Analysis Foundation. Denver, Colorado. November 2018.

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Clinical Pathways and Measures Committee – March 25, 2022
Pharmacy & Therapeutics Committee – March 3, 2022

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COLORADO SPRINGS REVIEWED BY	 Michael DiStefano, MD Chief Medical Officer, Colorado Springs
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REVIEW | REVISION SCHEDULE

Scheduled for full review March 25, 2026

Discrimination is Against the Law. Children's Hospital Colorado complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Children's Hospital Colorado does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Children's Hospital Colorado provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). Children's Hospital Colorado provides free language services to people whose primary language is not English, such as: Qualified interpreters, information written in other languages.

If you need these services, contact the Medical Interpreters Department at 720.777.9800.

If you believe that Children's Hospital Colorado has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Corporate Compliance Officer, 13123 E 16th Avenue, B450, Aurora, Colorado 80045, Phone: 720.777.1234, Fax: 720.777.7257, corporate.compliance@childrenscolorado.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Corporate Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-720-777-9800.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-720-777-9800.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-720-777-9800 번으로 전화해 주십시오

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-720-777-9800。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-720-777-9800.

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-720-777-9800 (መስማት ለተሳናቸው.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-720-777-9800 (رقم)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-720-777-9800.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-720-777-9800.

ध्यान दनु होस्तपाइले नेपाल बोल्नहन्छ भन तपाइको निम्त भाषा सहायता सवाहरू नःशल्क रूपमा उपलब्ध छ । फोन गनु होसर् 1-720-777-9800 ।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-720-777-9800.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-720-777-9800 まで、お電話にてご連絡ください。

Ntị: Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka. Call 1-720-777-9800.