

STD CLINIC PROCEDURES

HEPATITIS B VACCINATION

1. All patients receive Hepatitis B vaccination education sheet (Hepatitis B the Only STD With a Vaccine) and self-administered form (HHS:DC-31a) when they register at desk. Education handout has English on one side and Spanish on flip side. Self-administered HHS:DC-31a is available in either English or Spanish.

2. Patient completes self-administered HHS:DC-31a and turns it in to clerical staff with the rest of registration paperwork. The clerical person should check that the patient has completed the form (both front and back). However, completion of the form is voluntary and if the patient refuses to complete the form the clerk should not persist.

3. Clinician/nurse reviews form (HHS:DC-31a) to determine if patient has indicated Yes (wants vaccine), No (declines vaccine) or Not Sure.
 - **Accepted:**
 - a. All patients are given the Vaccine Information Statement (VIS), the current CDC form (12/16/1998; English or Spanish), and assisted in reviewing the form so they fully understand the risks and benefits of the vaccine.
 - b. Indicate STD clinic site (Rosecrans, East, Oceanside or South Bay)
 - c. Have patient read Hepatitis B Vaccine Administration/Consent Form (HHS:DC-30) (English or Spanish) and sign under “Patient Signature”.
 - d. If patient is less than 19 years of age have the patient review the Vaccines For Children (VFC) form, and ask whether patient meets any of the criteria listed; **if yes**, indicate on HHS:DC-30; **if no** circle “does not qualify”. There is no need to complete the VFC form for any patient.
 - e. Check Vaccine Given box on form HHS:DC-31a and initial

- f. Clinician/nurse indicates the VIS Form Date (found on lower left corner, side 2, of CDC handout) on line after patient's signature and date.
- g. Clinician/nurse prepares and administers vaccine, and records date, Manufacturer and lot #, site of vaccination, and signature on the HHSA:DC-30 form.
- h. Patient is given an "expedited appointment" reminder card which indicates need to return for next dose after the minimum time interval date:

Dose 1 = 0 days

Dose 2 = 28 days (1 month or 4 weeks) after dose 1

per Dr. Gunn you may give dose 2 if the patient appears in clinic up to 3 days before day 28

Dose 3 = 112 days (4 months or 16 weeks) after dose 1 and at least 56 days (2 months or 8 weeks) after dose 2. Please note: there must be a minimum of 4 months or 16 weeks between dose 1 and dose 3 and at least two months or eight weeks between dose 2 and dose 3.

FOR EXAMPLE:

Mr. and Mrs. Smith come to the clinic together; they both receive dose #1 on January 1, 1999; Mr. Smith returns for dose 2 on February 1, 1999; he is not eligible for dose #3 until May 1, 1999 (needs 4 months between dose #1 and #3). Mrs. Smith returns for dose #2 on March 15, 1999; she is eligible for dose #3 any time after May 15, 1999 (which will be 5.5 months after dose #1 but only 2 months after dose #2).

- **Not Sure:**
 - a. Address concerns/questions of patient; after final decision follow “Accepted” or “Declined” procedures.
 - b. As stated above, patients who have numerous questions or seem to be unsure about accepting the vaccine may be told: “You seem to have many concerns about the vaccine so I recommend you take these materials home and review them and not get the vaccine at this time.” It is not expected that clinic staff will spend an inordinate amount of time to convince a patient to receive the vaccine.

- **Declined:**
 - a. Re-offer vaccine (unless reason for decline is: “had all 3 shots” or “had Hepatitis B”).
 - b. If the patient still declines, reconfirm the reason on form HHSA:DC-31 by checking Vaccine Declined box; indicate reason and initial.

- **PUT PATIENT LABEL ON ALL FORMS (HHSA:DC-30 and HHSA:DC-31)**
 - **HHSA:DC-30 stays in medical record whether the patient accepts or declines vaccine; if the patient gets tested and is found to be hepatitis B positive a line should be drawn through the consent form signature area so no more doses of vaccine will be administered.**
 - **HHSA:DC-31 is set aside for Hepatitis B data entry staff (at East, Oceanside and South Bay) these forms will be sent via interdepartmental mail to: Paula Murray, MS-P511B)**

- 4. Patients returning for vaccine doses 2 and 3 will be expedited through the clinic since they will not **usually** require a clinician exam (see below for when an exam is suggested at time of dose #3).
 - a. Return patients will again sign the appropriate line on the HHSA:DC-30 and be offered another copy of the CDC VIS.
 - b. Clinician/nurse will complete appropriate line of HHSA:DC-30.

- c. All STD patients receiving dose #2 or dose #3 of the hepatitis B vaccine will have the most recent Dose 2/3 form (HHS:DC-32 7/1999) completed by the nurse at the time the dose is administered.
- d. If the patient received dose #1, or doses #1 and #2, somewhere else (such as at their private M.D. or in the military) they need to complete the Hepatitis B Vaccine risk assessment form (HHS:DC-31a 5/99) to accompany the Dose #2/Dose #3 form.
- e. Please be sure to indicate whether it is a #2 or #3 dose being administered by marking the appropriate statement:
 - Vaccine Dose #2
 - Vaccine Dose #3
- f. The Dose 2/3 form has two check-off boxes which should be marked if they apply to that particular dose:
 - a) Patient referred by a CDI for hepatitis B vaccine: this indicates that the patient is a close contact to a person known to have infectious hepatitis B and has been referred in by one of the Field Staff for testing and vaccination.
 - b) Patient started the series at a different project site.
 Location _____: this indicates that the patient began the hepatitis series at one of several community sites which is participating in the Hepatitis Immunization Program; for whatever reason they are unable to complete the series where they began and have been referred to the STD Clinic for completion.

If either or both apply, please mark the box. For b, list where the patient began the series, i.e. jail, drug treatment program, etc.

- g. Since patients coming back for only dose #3 may not have had an STD examination for several months some new items have been added to trigger STD evaluation of high-risk individuals.

For all patients receiving dose #3 who have not seen the clinician at this visit, the person administering the vaccine needs to answer the questions at the bottom of the form:

Is the patient High-Risk? [injection drug user (IDU), commercial sex worker (CSW), men having sex with men (MSM), HIV infected (900), or have history of bacterial STD (gonorrhea, chlamydia or syphilis only) in past 5 years]

- Yes
- No

Is the patient less than (<) 20 years old?

Yes

No

If YES to any of the above, obtain a urine specimen for CT, LE (males) and GC. This will require that a pink or blue (clinic visit) sheet be created to document the visit date and the test results.

On the Dose #2/#3 (HHS:DC-32) form complete the **Check tests ordered** area:

CT

GC

LE Test (*do while patient waits*)

circle the result:

NEG, trace, 1+, 2+

If LE test is trace, 1+ or 2+ send patient to clinician for evaluation and treatment. The clinician will then complete the clinic visit form and a CT/GC lab form after a more thorough history is taken. If the LE test is negative, or not done (for females), the nurse will complete the clinic visit form (see Appendix B) and prepare a CT/GC lab form (see Appendix A.)

h. Miscellaneous reminders:

- 1) Be sure there is a **patient sticker** attached to each and every form. If stickers are unavailable during the clinic, the patient name, id number, date of birth, sex, and race must be handwritten on the form.
- 2) Indicate which clinic the form comes from: Rosecrans, East, Oceanside, or SouthBay
- 3) Please take care to clearly indicate whether the patient received the dose or not. Many forms come through with no indication of whether or not the vaccine was actually given.

i. All Hepatitis B Vaccine forms should be sent via interdepartmental mail at the end of each clinic (except Rosecrans where the forms are picked up) to:

Paula Murray
Hepatitis B Program
MS P511-B

j. Clinician/nurse will complete Hepatitis B Vaccine Dosage #2 & #3 Dispense Form (HHS:DC-32 7/99), and will place it in HBV data entry box (At East and

Oceanside these forms will be sent via interdepartmental mail to: Paula Murray, MS – P511B).

Miscellaneous Issues:

1. Walk-in requests for Hepatitis B vaccine:

Patients walking in to the STD clinic requesting only Hepatitis B vaccine (do not confuse these with STD patients returning for dose 2 or 3) should be referred to community clinics. The standard response is: “Hepatitis B vaccine is offered as part of the STD examination and treatment service – it is not available for the general public at this facility”.

2. Adverse Reactions:

In the unlikely event that a patient calls or walks into the STD clinic complaining of a suspected adverse reaction to the Hepatitis B vaccine the following guidelines should be followed:

- a. The patient (caller) should be triaged to a nurse or clinician along with the patient’s medical chart.
- b. The nature of the complaints should be documented in a progress note and an assessment made of the seriousness of the complaint.
- c. The patient should be advised to go to an emergency care facility if the symptoms seem to be life-threatening or serious.
- d. If the complaints are not life-threatening the patient should be advised to seek medical care with his/her usual medical care provider. If the patient does not have a provider he/she should be given the address and telephone number of community clinics.

- e. If the patient states that the County of San Diego is responsible for the medical problem, the patient may file a claim. The patient should be given the number of the Claims Division to request a form: 531-4900. No promise of assistance from the STD clinic or from the County of San Diego # should be implied.

If the patient insists on speaking to someone else, the following list indicates the appropriate staff (in order of who to contact first) to refer the patient to:

1. Public Health Nurse Manager
2. Bob Gunn, M.D.
3. Michele Ginsberg, M.D.

3. Clinician discretion:

At the discretion of the clinician, based on the needs of the patient, it may be decided that a patient should not be given the vaccine at this time. Each clinician will make these decisions after review of the patient's individual medical history and condition and weighing the risk of vaccination against the risk of acquiring hepatitis B.

4. Clinic Capacity Issues:

If clinic capacity for the day has been reached and patients are being triaged, the triage nurse will determine whether patients requesting Hepatitis B vaccine dose 2 or 3 can be seen within clinic hours. The PHN Manager will be contacted to provide vaccine, if possible, before these patients are turned away.

9/24/1999

HEPATITIS B VACCINE CONSENT FORM

Patient Sticker Here:

Review self-administered form (DC-31) with patient. If patient has accepted vaccine continue with this form and administer vaccine. If patient has declined, re-offer vaccine and address any concerns of the patient. If patient still declines, confirm reason on form DC-31.

VFC Category (for children <19 years old): 1 2 3 4 Does not qualify

VACCINE ADMINISTRATION

Hepatitis B

Dose #	Date Given	Mfr. & Lot #	Site*	Administered By**
#1				
#2				
#3				

*Site = RD or LD - left or right deltoid **First initial, last name, title (e.g., S. Smith, RN)

I have been given a copy and have read, or have had explained to me, the information contained in the vaccine information statement about the disease and vaccine indicated below. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the Hepatitis B vaccine be given to me. Also, I understand that if I do not return for doses 2 and 3, I may be contacted.

Me han dado una copia y he leído, o me han dado una explicación sobre la información contenida en el folleto que habla sobre la enfermedad de hepatitis B y su vacuna. He tenido la oportunidad de hacer preguntas, las cuales han sido contestadas a mi completa satisfacción. Entiendo los beneficios y los riesgos de la vacuna y pido que me den esta vacuna. Entiendo si no regreso para las vacunas 2 y 3, es posibilidad que se comunican conmigo.

Hepatitis B

Patient Signature	Date	VIS Form Date

THIS FORM TO REMAIN IN MEDICAL RECORD

STD/HEPATITIS RISK QUESTIONNAIRE

Please complete this form. All information is CONFIDENTIAL and will help identify the services you need.

NAME: _____

DATE OF BIRTH: _____

SEX: MALE FEMALE

TODAY'S DATE: _____

1. What is the reason for your visit? (check all that apply)
- Have symptoms such as discharge, sore, rash or _____
 - No symptoms-want a check up and/or tests
 - Told or think you might have been exposed to an STD
 - Told to come in by an (STD) investigator
 - Want hepatitis services
 - Other: _____

2. Have you had sex in the last 3 months? Yes No

With how many persons? 1 2 3 4 5 more than 5

3. My sex partners are: Men Women Both

OFFICE USE ONLY		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	Avac	Ø

4. How many people have you had sex with during your **lifetime**?
(circle the closest number)

If you answer **none**, turn the page over and go to question #8

0 1 2 3 4 5 10 15 25 30 50 75 100 More than 100

5. When you have sex, do you use a condom?
- Always Most of the time Sometimes
 - Rarely Never

6. Have you ever paid for sex, or traded sex for money or drugs?
- Yes No

OFFICE USE ONLY			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
♀	B	C	Ø

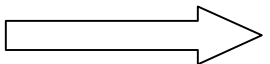
7. Check the box by any disease you have had in the last 5 years:

- Syphilis (bad blood) # of times _____
- Gonorrhea (clap) # of times _____
- Chlamydia # of times _____
- Trichomonas ("trick") # of times _____
- Sex Warts
- Herpes
- HIV
- Women – infection in your tubes/womb (PID) # of times _____
- Men – burning or drip from penis (not gonorrhea or chlamydia)

Patient Sticker Here

TURN THE PAGE OVER

- Rosecrans Central Region
- South Region North Coastal



8. Did you have a blood transfusion before 1992? Yes No

9. Have you ever injected drugs? Yes No

10. **If you answered YES to #9**, please complete the following:

a) Did you ever share needles? Yes No

If YES: Most of the time Sometimes Rarely Only once

b) Did you ever share "works"? Yes No

If YES: Most of the time Sometimes Rarely Only once

c) How old were you the first time you injected? _____

d) Have you injected drugs in the last 12 months? Yes No

e) Check the box which best describes your level of injection drug use:

Less than 10 times in your lifetime

Used for 1 year or less

Used for _____ years

Current user: Have been using for _____ years

11. Have any of your sex partners used injection drugs?

Yes No Not sure

If Yes, who was it? (check all that apply)

current sex partner past sex partner

12. Have you had sex with someone who has hepatitis B or C?

Yes No Not sure

13. Have you ever been in jail or prison? Yes No

14. How often do you cross the US-Mexico border?

Every day 2-6 times/week once a week once a month

2-6 times/year once a year less than once a year never

15. How long do you usually stay on the Mexican side of the border?

I do not stay on the Mexican side 1-3 days more than 3 days

16. Are you interested in starting the hepatitis B vaccine today?

Yes No Not Sure

If NO, why not? I've already had all 3 vaccine shots

I've had Hepatitis B

Other reason _____

OFFICE USE ONLY			
<input type="checkbox"/>			<input type="checkbox"/>
	C		Ø
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	C	Avac	Ø

OFFICE USE ONLY			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	B	C	Ø
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	B	C	Ø

OFFICE USE ONLY

Hep B Vaccine Given _____(initials)

Hep B Vaccine Not Given _____(initials)

Patient referred by CDI for hep B testing and/or vaccine

Patient started vaccine at _____

<u>OFFICE USE ONLY</u>			
Counselor	_____		
Clinician	_____		
Nurse	_____		
IDU	<input type="checkbox"/>	900	<input type="checkbox"/>
MSM	<input type="checkbox"/>	CSW	<input type="checkbox"/>
HBV/HCV contact	<input type="checkbox"/>		
IDU contact	<input type="checkbox"/>		

QUESTIONARIO DEL RIESGO DE ENFERMEDADES VENEREAS/HEPATITIS

Por favor complete este formulario. La información es completamente CONFIDENCIAL y nos ayudará a identificar los servicios que usted necesita.

NOMBRE: _____

FECHA DE NACIMIENTO: _____

SEXO: MASCULINO FEMENINO

FECHA DE HOY: _____

1. Cuál es la razón de su visita? (marque todo lo que aplique)
- Tiene síntomas tales como desecho, inflamación, picazón o _____
 - No tiene síntomas. Solo quiere un examen.
 - Le dijeron o piensa que pueda haber estado expuesto a alguna enfermedad venerea.
 - Un empleado de la clinica (Investigador) le dijo que viniera.
 - Quiere servicios sobre la hepatitis.
 - Other _____

2. Ha tenido relaciones sexuales en los últimos 3 meses? Sí No
Con cuántas personas? 1 2 3 4 5 más de 5

OFFICE USE ONLY
B Avac Ø

3. Mis parejas de sexo son: Hombres Mujeres Ambos

4. Con cuántas personas durante **toda su vida** usted ha tenido relaciones sexuales (marque con un círculo el número más cercano)? Si contestó zero, pase a la pregunta #11
0 1 2 3 4 5 10 15 25 30 50 75 100 Más de 100

5. Cuándo tiene relaciones sexuales, usa usted un condón?
- Siempre La mayoría de las veces Algunas veces
 - Raramente Nunca

OFFICE USE ONLY
♀ B C Ø

6. Ha pagado dinero a alguien para tener relaciones sexuales?
 Sí No

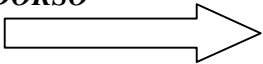
7. Marque los cuadros que indican las enfermedades que haya tenido en los últimos **5 años**

- Sífilis _____ veces Verrugas Venéreas
- Gonorrea _____ veces VIH
- Clamidia _____ veces Herpes
- Tricomoniiasis _____ veces
- Mujeres - infección en los tubos/útero (Enfermedad Inflamatoria Pélvica) _____ veces
- Hombres - ardor o goteo del pene (no gonorrea o clamidia) _____ veces

Patient Sticker Here

HHSA: DC-31s (3/01)

CONTINUE AL DORSO



- Rosecrans Central Region
 - South Region North Coastal
- County of San Diego, Health and Human Services Agency

8. Ha tenido tranfusión de sangre antes del año 1992? Sí No

9. Alguna vez se ha inyectado drogas? Sí No

10. Si es SI, por favor complete lo siguiente:

a) Ha compartido las agujas con otra persona? Sí No

Si es SI: Todo el tiempo Algunas veces Raramente Solamente una vez

b) Ha compartido "works" con otra persona? Sí No

Si es SI: Todo el tiempo Algunas veces Raramente Solamente una vez

c) Que edad tenía usted la primera vez que se inyectó? _____

d) Durante los últimos 12 meses, se ha inyectado drogas? Sí No

e) Marque el cuadro que más describe su nivel de uso de drogas inyectables:

Menos de 10 veces en su vida Usé por _____ años

Usé por un año o menos Actualmente usando por _____ años

OFFICE USE ONLY			
	C		Ø
B	C	Avac	Ø

11. Ha tenido algún compañero de sexo que se ha inyectado drogas?

Sí No No Estoy Seguro

Si es SI, quien fue? (marque todo lo que aplique)

Pareja Actual Ex-Pareja

12. Ha tenido relaciones sexuales con alguien que tenga hepatitis B o C?

Sí No No Estoy Seguro

OFFICE USE ONLY		
B	C	Ø
B	C	Ø

13. Alguna vez ha estado encarcelado? Sí No

14. Cuantas veces usted cruza la frontera entre Estados Unidos y Mexico?

Cada Dia 2-6 veces a la semana Una vez a la semana Una vez al mes
 2-6 veces al año Una vez al año Menos que una vez al año Nunca

15. Usualmente cuanto tiempo, se hospeda en el lado Mexicano?

No me hospedo en el lado Mexicano 2-6 veces al año
 1 - 3 dias Más de 3 dias
 Una vez al mes

16. Está usted interesada(o) en empezar la vacuna de la Hepatitis B hoy?

Sí No No Estoy Seguro

Si es NO, por qué no? (marque todo lo relativo a usted)

Ya he recibido las 3 vacunas Yo he tenido la Hepatitis B
 Otra razón _____

OFFICE USE ONLY	
Counselor	_____
Clinician	_____
Nurse	_____
IDU	900
MSM	CSW
HBV/HCV contact	
IDU contact	

OFFICE USE ONLY

Hep B Vaccine Given _____(initials) Patient referred by CDI for hep B testing and/or vaccine
 Hep B Vaccine Not Given _____(initials) Patient started vaccine at _____

Instructions for STD / Hepatitis Risk Questionnaire

The following is a summary of hepatitis services within the STD Clinic and how to use the **new and improved STD/HEPATITIS RISK QUESTIONNAIRE**. The form has been designed to assist in the identification of high-risk clients and the services they are eligible to receive. **REMINDER: All clients should be offered hepatitis B vaccine.**

TESTING SERVICES:

Clients at **high-risk, or possibly at high-risk**, for hepatitis B or hepatitis C should be offered serological testing. The recommendation for testing may be made by the Clinician, the Nurse or the HIV Counselor.

The STD/HEPATITIS RISK QUESTIONNAIRE (HHS:DC-31a 1/2001) has been revised to assist in the identification of those clients who meet testing and hepatitis A vaccination criteria. **The boxes on the right-hand side of the revised form need to be completed for every patient by whichever staff member sees patient first (usually the counselor).** Codes in the boxes are defined below:

B = HBV testing C = HCV testing A _{vac} = Hepatitis A vaccine ♀ = Female clients only ∅ = Client not high-risk for HBV or HCV or hepatitis A vaccine; these clients should not be offered these services; this box will be the one most frequently checked.

For the last box on the back side of the STD/HEPATITIS RISK QUESTIONNAIRE all staff who review the form should place their initials on the appropriate line.

Counselor _____ Nurse _____ Clinician _____

If, through discussion with the patient, you discover that they have high-risk behaviors which they did not indicate on the STD/HEPATITIS RISK QUESTIONNAIRE **do not make any changes to the patient-completed entries**. Instead, indicate the risk (or risks) by checking the appropriate box(es) as described below:

IDU = injection drug use ever
900 = HIV infected
MSM = men having sex with men
CSW = female commercial sex worker
IDU Contact = Sex partner of an IDU
HBV/HCV Contact = the sex partner of someone infected with
HBV or HCV

Based on this information you may then offer the patient any hepatitis services for which they qualify (see specific criteria below). Be sure to indicate this risk information on the Hepatitis Lab Form.

The HIV Counselors will be reviewing most STD/HEPATITIS RISK QUESTIONNAIRES, however, clinicians and nurses should review each form and initial.

The following criteria identify those patients eligible for testing services:

Both Hepatitis B & Hepatitis C testing:

- ✓ Injection drug user (past or present)
- ✓ Sex partner of injection drug user
- ✓ Sex partner of an individual known to be chronically infected with hepatitis
- ✓ Female commercial sex worker

Hepatitis B testing only:

- ✓ Men who have sex with men

Hepatitis C testing only:

- ✓ Received a blood transfusion or other blood products prior to 1992

These criteria identify most high-risk individuals, however, at the discretion of the clinician, other patients may be offered hepatitis B or C testing.

Other testing guidelines:

- ✓ Patients who have tested indeterminant for HCV should not be re-tested until six months from the date of the indeterminant test.
- ✓ If a patient has previously been tested (for hepatitis B or C) in the STD Clinic and tested negative (not infected) but continues to engage in high-risk activity, they may have the test repeated six months from the date of the first test.

- ✓ The hepatitis services offered in the STD Clinic are for STD patients – patients should not be referred to the clinic for confirmatory testing of their hepatitis B or C status from other clinics/agencies/blood bank, etc. Patients referred for “confirmation” of their hepatitis (B or C) status should not be tested.

VACCINATION SERVICES:

Hepatitis B Vaccine:

Every patient of the STD Clinic should be offered hepatitis B vaccine. Currently, 72% of eligible patients (not already vaccinated or not already immune) accept the hepatitis B vaccine. Unfortunately, the highest-risk patients, IDU and MSM, accept at lower rates of 67% and 68% respectively. A few extra minutes spent exploring why high-risk clients decline the vaccine would provide valuable information (to be documented on the “HIGH-RISK CLIENTS WHO DECLINE HEPATITIS SERVICES WORKSHEET”) and might result in more of these clients accepting the vaccine.

Return rates for doses 2 and 3 are not as high as anticipated, 49% return for dose 2 and 25% return for dose 3. Please spend a moment educating patients that they are not fully protected until they receive all the doses. You might also emphasize how expensive the vaccine is if they ever wanted to finish the series through a private physician or health care plan.

Hepatitis A Vaccine:

Hepatitis A vaccine is offered to patients who meet the following criteria:

- ✓ Men who have sex with men
- ✓ Injection drug user (past or present)
- ✓ Any individual who is chronically infected with HBV or HCV

Instructions for Hepatitis B Vaccine Dose 2 & 3 Form

This memo is to clarify the use of the DC-32 (5/99) Hepatitis B Vaccine Dose #2 and Dose #3 Form (attached for reference). This form should replace all previous versions of the Dose 2/3 form.

1. All STD patients receiving dose #2 or dose #3 of the hepatitis B vaccine should have this form completed by the nurse at the time the dose is administered.
2. If the patient received dose #1, or doses #1 and #2, somewhere else (such as at their private M.D. or in the military) they need to complete the Hepatitis B Vaccine risk assessment form (HHS:DC-31a 5/99) to accompany the Dose #2/Dose #3 form.
3. Please be sure to indicate whether it is a #2 or #3 dose being administered by circling the appropriate statement (marked by X on the attached form):
 Vaccine Dose #2
 Vaccine Dose #3
4. As described in the memo of May 24, 1999 this new form has two check-off boxes which should be marked if they apply to that particular dose:
 - a) Patient referred by a CDI for hepatitis B vaccine
 - b) Patient started the series at a different project site.
 Location_____

If either or both apply, please mark the box. For b, list where the patient began the series, i.e. jail, drug treatment program, etc.

5. Since patients coming back for only dose #3 may not have had an STD examination for several months some new items have been added to trigger STD evaluation of high-risk individuals.

For all patients receiving dose #3 who have not seen the clinician at this visit, the person administering the vaccine needs to answer the questions at the bottom of the form:

Is the patient High-Risk? [commercial sex worker (CSW), men having sex with men (MSM), HIV infected (900), or have history of bacterial STD in past 5 years]

Yes

No

Is the patient less than (<) 20 years old?

Yes

No

If YES to any of the above, please obtain a urine specimen for CT, LE (males) and GC.

Complete the **Check tests ordered** area:

CT

GC

LE Test (*do while patient waits*)

circle the result:

NEG, trace, 1+, 2+

If LE test is trace, 1+ or 2+ send patient to clinician for evaluation and treatment.

6. Miscellaneous reminders:

- 1) Be sure there is a patient sticker attached to each and every form. If stickers are unavailable during the clinic, the patient name, id number, date of birth, sex, and race must be written on the form.
- 2) Indicate which clinic the form comes from: Rosecrans, East, Oceanside, or SouthBay
- 3) Please take care to clearly indicate whether the patient received the dose or not. Many forms come through with no indication of whether or not the vaccine was actually given.

Place Patient Label Here

Date: _____

Central Region PHC

North Coastal PHC

Rosecrans

South Region PHC

Check when given

**HEPATITIS B VACCINE
DOSE #2**

- Patient referred by a CDI for Hepatitis B vaccine.
- Patient started the series at a different project site. Location: _____
- Patient started with pregnancy testing.

Check when given

**HEPATITIS B VACCINE
DOSE #3**

- Patient referred by a CDI for Hepatitis B vaccine.
- Patient started the series at a different project site. Location: _____
- Patient started with pregnancy testing.

For Nurse or Clinician Use Only:

1. Is the patient High-Risk? (CSW, MSM, IDU, 900, or have history of bacterial STD in past 5 years)
 Yes No
2. Is the patient < 20 years old?
 Yes No

If 1 or 2 above is **YES** obtain a urine specimen for CT, GC and LE (males) testing.

- Notify receptionist of testing to obtain DC-245 (Blue) or DC-246 (Pink) and LCR lab slip (Green)
- Complete the LCR lab slip and check which tests were ordered below:
 CT GC
- While patient waits, perform LE test and mark result below:
 - NEG** – Submit urine specimen for testing. No need to send patient to clinician.
 - TRACE** – Send patient to clinician for evaluation and treatment
 - 1+** - Send patient to clinician for evaluation and treatment
 - 2+** - Send patient to clinician for evaluation and treatment

High-Risk Clients Who Decline Hepatitis Services

Clinic Staff: Please complete this form whenever a high-risk patient declines any hepatitis service recommended for their risk group. Indicate the criteria which qualify them for each service. Thank you.

1. TESTING for hepatitis B:

MSM IDU partner IDU partner chronic hepatitis (B or C) female CSW
 Other _____

<input type="checkbox"/> Had hepatitis B/is chronic HBV	<input type="checkbox"/> Recently tested
<input type="checkbox"/> Afraid to know test result	<input type="checkbox"/> Not worried about hepatitis
<input type="checkbox"/> Does not want blood drawn	<input type="checkbox"/> Does not want extra tube of blood drawn
<input type="checkbox"/> Other reason _____	

2. TESTING for hepatitis C:

IDU partner IDU partner chronic hepatitis (B or C) female CSW
 blood transfusion before 1992 Other _____

<input type="checkbox"/> Knows they are infected	<input type="checkbox"/> Recently tested
<input type="checkbox"/> Afraid to know test result	<input type="checkbox"/> Not worried about hepatitis
<input type="checkbox"/> Does not want blood drawn	<input type="checkbox"/> Does not want extra tube of blood drawn
<input type="checkbox"/> Other reason _____	

3. VACCINATION for hepatitis A:

MSM IDU chronic HBV chronic HCV Other _____

<input type="checkbox"/> Already had vaccine series	<input type="checkbox"/> Doesn't like shots/needles
<input type="checkbox"/> Had hepatitis A	<input type="checkbox"/> Will get from regular M.D.
<input type="checkbox"/> Not worried about hepatitis	<input type="checkbox"/> Other reason _____

4. VACCINATION for hepatitis B:

MSM IDU HCV partner IDU partner chronic hepatitis (B or C) Other _____

<input type="checkbox"/> Already had vaccine series	<input type="checkbox"/> Doesn't like shots/needles
<input type="checkbox"/> Had hepatitis B	<input type="checkbox"/> Will get from regular M.D.
<input type="checkbox"/> Not worried about hepatitis	<input type="checkbox"/> Other reason _____

MARK STD CLINIC SITE:

Rosecrans Central Region PHC
 North Coastal PHC South Region PHC

FORM COMPLETED BY:

Counselor _____ (init.)
 Clinician _____ (init.)
 Nurse _____ (init.)

PATIENT STICKER HERE

Return this form to:
Hepatitis Services
P-511B

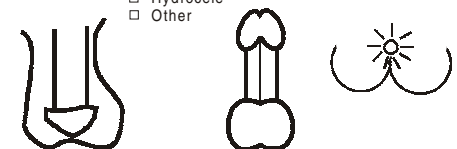
**HEALTH & HUMAN SERVICES AGENCY
Sexually Transmitted Diseases Clinic Record - MALE**

	CLINIC SITE: <input type="checkbox"/> Rosecrans <input type="checkbox"/> Central <input type="checkbox"/> South <input type="checkbox"/> N. Coastal	TYPE OF VISIT <input type="checkbox"/> New <input type="checkbox"/> Follow-Up <input type="checkbox"/> Massage <input type="checkbox"/> Hep B Vaccine <input type="checkbox"/> Case Management <input type="checkbox"/> CT Retest	Patient Number _____ Best Contact _____
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I verify that the above information is correct and I consent to testing and treatment for sexually transmitted diseases by the County of San Diego, Health & Human Services Agency.
 Signature: _____ Date: _____ Witness: _____

REASON FOR VISIT <input type="checkbox"/> Symptoms <input type="checkbox"/> Check-Up <input type="checkbox"/> Referral <input type="checkbox"/> Treatment Only <input type="checkbox"/> Lab Only <input type="checkbox"/> Hepatitis Services	REFERRED BY <input type="checkbox"/> Partner <input type="checkbox"/> CDI <input type="checkbox"/> Physician <input type="checkbox"/> Treatment Center <input type="checkbox"/> Other	REFERRAL DISEASE <input type="checkbox"/> CT <input type="checkbox"/> Syphilis <input type="checkbox"/> NGU <input type="checkbox"/> Trich <input type="checkbox"/> MPC <input type="checkbox"/> HPV <input type="checkbox"/> GC <input type="checkbox"/> HSV <input type="checkbox"/> PID <input type="checkbox"/> Hepatitis <input type="checkbox"/> Contact to above	SEX IN PAST 3 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No LSE: _____ Total # Of Partners In Past 3 Months _____ # of New Partners _____	LAST HIV TEST <input type="checkbox"/> Never <input type="checkbox"/> >6 months <input type="checkbox"/> <6 months RESULTS <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Ind <input type="checkbox"/> ???	
SYMPTOMS <input type="checkbox"/> None <input type="checkbox"/> Discharge <input type="checkbox"/> Dysuria <input type="checkbox"/> Genital Itching <input type="checkbox"/> Other Itching <input type="checkbox"/> Lesion <input type="checkbox"/> Rash <input type="checkbox"/> Scrotal Pain <input type="checkbox"/> Other	DAYS _____ _____ _____ _____ _____ _____ _____	STD HISTORY <input type="checkbox"/> None <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> NGU <input type="checkbox"/> Trichomonas <input type="checkbox"/> Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Syphilis	DATES _____ _____ _____ _____ _____ _____ _____	Exposure Sites <input type="checkbox"/> Oral <input type="checkbox"/> Penis <input type="checkbox"/> Anal Insertive <input type="checkbox"/> Anal Receptive	TRAVEL (Past 60 days) <input type="checkbox"/> Hawaii/Asia/Pacific <input type="checkbox"/> Mexico/Central/South America
If Seen Within 30 Days: Persistent Symptoms Y N New Symptoms Y N Describe _____	ANY MEDICATIONS PAST 2 WEEKS? Antibiotics Y N Name: _____ Other Meds Including OTC Items Y N _____ Existing Medical Conditions: _____	PARTNER GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both	RISK FACTORS (Lifetime) IDU Y N Share Works Y N Last Use _____ Drug _____ Partner IDU Y N CSW Y N Sex with CSW Y N Male Partners Y N Condom Use Y N		
Sex Since Last Visit? <input type="checkbox"/> No <input type="checkbox"/> Former <input type="checkbox"/> New Partners Treated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Comments _____ _____ _____					

Physical Examination Not Done Genital Only

Oro-Pharynx <input type="checkbox"/> WNL <input type="checkbox"/> Ulcer <input type="checkbox"/> Exudate <input type="checkbox"/> Inflamed <input type="checkbox"/> Other	Extragenital Nodes <input type="checkbox"/> WNL <input type="checkbox"/> Cervical <input type="checkbox"/> Axillary <input type="checkbox"/> Epitrochlear <input type="checkbox"/> Other	Inguinal Nodes <input type="checkbox"/> WNL <input type="checkbox"/> Enlarged <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Tender <input type="checkbox"/> Other	Penis <input type="checkbox"/> WNL <input type="checkbox"/> Uncircumcised <input type="checkbox"/> Discharge <input type="checkbox"/> Ulcer <input type="checkbox"/> Vesicle <input type="checkbox"/> Warts <input type="checkbox"/> Balanitis <input type="checkbox"/> Rash <input type="checkbox"/> Molluscum <input type="checkbox"/> Other	Scrotal Contents <input type="checkbox"/> WNL <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Tender <input type="checkbox"/> Swollen <input type="checkbox"/> Mass <input type="checkbox"/> Hydrocele <input type="checkbox"/> Other	Anal <input type="checkbox"/> Not Done <input type="checkbox"/> WNL <input type="checkbox"/> Warts <input type="checkbox"/> Discharge <input type="checkbox"/> Ulcer <input type="checkbox"/> Other
Skin <input type="checkbox"/> WNL <input type="checkbox"/> P & P Rash <input type="checkbox"/> Other Rash <input type="checkbox"/> Folliculitis <input type="checkbox"/> Intertrigo <input type="checkbox"/> Molluscum <input type="checkbox"/> Scabies <input type="checkbox"/> Other	Pubic Hair <input type="checkbox"/> WNL <input type="checkbox"/> Crabs/Nits <input type="checkbox"/> Other				
Comments On Physical Findings _____ _____					


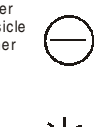
**HEALTH & HUMAN SERVICES AGENCY
Sexually Transmitted Diseases Clinic Record - FEMALE**

	CLINIC SITE: <input type="checkbox"/> Rosecrans <input type="checkbox"/> Central <input type="checkbox"/> South <input type="checkbox"/> N. Coastal	TYPE OF VISIT <input type="checkbox"/> New <input type="checkbox"/> Follow-Up <input type="checkbox"/> Massage <input type="checkbox"/> Hep B Vaccine <input type="checkbox"/> Case Management	Patient Number _____ Best Contact _____
--	--	--	---

I verify that the above information is correct and I consent to testing and treatment for sexually transmitted diseases by the County of San Diego, Health & Human Services Agency.
 Signature: _____ Date: _____ Witness: _____

REASON FOR VISIT <input type="checkbox"/> Symptoms <input type="checkbox"/> Check-Up <input type="checkbox"/> Referral <input type="checkbox"/> Treatment Only <input type="checkbox"/> Lab Only <input type="checkbox"/> Hepatitis Services	REFERRED BY <input type="checkbox"/> Partner <input type="checkbox"/> CDI <input type="checkbox"/> Physician <input type="checkbox"/> Other	REFERRAL DISEASE <input type="checkbox"/> CT <input type="checkbox"/> Syphilis <input type="checkbox"/> NGU <input type="checkbox"/> Trich <input type="checkbox"/> MPC <input type="checkbox"/> HPV <input type="checkbox"/> GC <input type="checkbox"/> HSV <input type="checkbox"/> PID <input type="checkbox"/> Hepatitis <input type="checkbox"/> Contact To Above	SEX IN PAST 3 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No LSE: _____ Total # Of Partners In Past 3 Months _____ Total # of New Partners _____	LAST HIV TEST <input type="checkbox"/> Never <input type="checkbox"/> >6 months <input type="checkbox"/> <6 months RESULTS <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Ind <input type="checkbox"/> ??? Contraception Use <input type="checkbox"/> None <input type="checkbox"/> Spermicide <input type="checkbox"/> Condoms <input type="checkbox"/> OCP <input type="checkbox"/> Diaphragm <input type="checkbox"/> BTL <input type="checkbox"/> Depot <input type="checkbox"/> IUD <input type="checkbox"/> Norplant <input type="checkbox"/> Other	
SYMPTOMS <input type="checkbox"/> None <input type="checkbox"/> Discharge <input type="checkbox"/> Dysuria <input type="checkbox"/> Genital Itching <input type="checkbox"/> Other Itching <input type="checkbox"/> Lesion <input type="checkbox"/> Rash <input type="checkbox"/> Abd/Pelvic Pain <input type="checkbox"/> Other	DAYS _____ _____ _____ _____ _____ _____ _____	STD HISTORY <input type="checkbox"/> None <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> PID <input type="checkbox"/> Trichomonas <input type="checkbox"/> Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Syphilis	DATES _____ _____ _____ _____ _____ _____	Exposure Sites <input type="checkbox"/> Oral <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal Receptive PARTNER GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both RISK FACTORS IVDU Y N Share Works Y N Last Use _____ Drug _____ Partner IVDU Y N CSW Y N Partner Bisexual Y N Condom Use _____ Pregnant Y N Trimester _____ Last Menses _____ <input type="checkbox"/> <30 Days <input type="checkbox"/> >30 Days <input type="checkbox"/> Abnormal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Other _____	TRAVEL (Past 60 days) <input type="checkbox"/> Hawaii/Asia/Pacific <input type="checkbox"/> Mexico/Central/South America
If Seen Within 30 Days: Persistent Symptoms Y N New Symptoms Y N Describe _____		ANY MEDICATIONS PAST 2 WEEKS? Antibiotics Y N Name: _____ Other Meds Including OTC Items Y N _____		Existing Medical Conditions: _____	
Sex Since Last Visit? <input type="checkbox"/> No <input type="checkbox"/> Former <input type="checkbox"/> New Partners Treated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Comments _____			

Physical Examination Not Done Genital Only

Oro-Pharynx <input type="checkbox"/> WNL <input type="checkbox"/> Ulcer <input type="checkbox"/> Exudate <input type="checkbox"/> Inflamed <input type="checkbox"/> Other	Extragenital Nodes <input type="checkbox"/> WNL <input type="checkbox"/> Cervical <input type="checkbox"/> Axillary <input type="checkbox"/> Epitrochlear <input type="checkbox"/> Other	Inguinal Nodes <input type="checkbox"/> WNL <input type="checkbox"/> Enlarged <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Tender <input type="checkbox"/> Other	Vulva/Vagina <input type="checkbox"/> WNL <input type="checkbox"/> Erythema <input type="checkbox"/> Abnormal Discharge <input type="checkbox"/> Ulcer <input type="checkbox"/> Vesicle <input type="checkbox"/> Warts <input type="checkbox"/> Rash <input type="checkbox"/> Menses <input type="checkbox"/> Other	Cervix <input type="checkbox"/> WNL <input type="checkbox"/> Ectopy <input type="checkbox"/> Discharge <input type="checkbox"/> Friable <input type="checkbox"/> Ulcer <input type="checkbox"/> Vesicle <input type="checkbox"/> Other	Bimanual <input type="checkbox"/> WNL <input type="checkbox"/> Motion Tenderness <input type="checkbox"/> Adnexal Tenderness <input type="checkbox"/> Adnexal Fullness <input type="checkbox"/> Mass <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other
Skin <input type="checkbox"/> WNL <input type="checkbox"/> P & P Rash <input type="checkbox"/> Other Rash <input type="checkbox"/> Folliculitis <input type="checkbox"/> Intertrigo <input type="checkbox"/> Molluscum <input type="checkbox"/> Scabies <input type="checkbox"/> Other	Abdomen <input type="checkbox"/> Not Done <input type="checkbox"/> WNL <input type="checkbox"/> Tenderness <input type="checkbox"/> Rebound <input type="checkbox"/> Mass <input type="checkbox"/> CVA Tenderness <input type="checkbox"/> Other	Pubic Hair <input type="checkbox"/> WNL <input type="checkbox"/> Crabs/Nits <input type="checkbox"/> Other			Rectal <input type="checkbox"/> Not Done <input type="checkbox"/> WNL <input type="checkbox"/> Warts <input type="checkbox"/> Discharge <input type="checkbox"/> Ulcer <input type="checkbox"/> Other
Comments On Physical Findings _____					

<p>STAT LABORATORY <input type="checkbox"/> None Ordered</p> <p><input type="checkbox"/> Wet Mount <input type="checkbox"/> WNL <input type="checkbox"/> Clue _____ % WBC <10 >10 <input type="checkbox"/> pH _____ <input type="checkbox"/> Amine Neg Pos <input type="checkbox"/> Hyphae Neg Pos <input type="checkbox"/> Buds Neg Pos <input type="checkbox"/> Trich Neg Pos <input type="checkbox"/> Darkfield Neg Pos <input type="checkbox"/> Stat RPR Neg Pos <input type="checkbox"/> Pregnancy Neg Pos <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> CERVICAL CYTOLOGY <input type="checkbox"/> NOT DONE</p> <p><input type="checkbox"/> WNL <input type="checkbox"/> LG Sil <input type="checkbox"/> Inflammation <input type="checkbox"/> Atypia <input type="checkbox"/> Hg Sil <input type="checkbox"/> Carcinoma <input type="checkbox"/> Reactive Cellular Changes <input type="checkbox"/> Other: _____</p>	<p>ROUTINE LABORATORY <input type="checkbox"/> None Ordered</p> <p><u>Gonorrhea Culture</u> <input type="checkbox"/> Cervix N P U <input type="checkbox"/> Urethral N P U <input type="checkbox"/> Anal N P U <input type="checkbox"/> Throat N P U <input type="checkbox"/> Urine LCR N P U</p> <p><u>Chlamydia</u> <input type="checkbox"/> Cervix N P U <input type="checkbox"/> Urine N P U</p> <p><u>Syphilis</u> <input type="checkbox"/> RPR Qual NR R U <input type="checkbox"/> RPR Quant NR Titer _____ <input type="checkbox"/> TPPA NR R U <input type="checkbox"/> DFA-TP N P U</p> <p><u>HSV</u> N I II U Site _____</p> <p><u>Hepatitis B</u> <input type="checkbox"/> Core Ab Total NR R U <input type="checkbox"/> Surface Ag NR R U</p> <p><u>Hepatitis C</u> <input type="checkbox"/> EIA NR R U <input type="checkbox"/> RIBA Neg Pos Ind</p> <p style="text-align: right;">Above Results Entered By: _____ Date: _____</p>	<p>HIV PRE AND POST TESTING</p> <p>HIV Pretest Counseled <input type="checkbox"/> Yes <input type="checkbox"/> No Accepts Testing <input type="checkbox"/> Yes <input type="checkbox"/> No Counselor: _____ Post Test Session Counselor: _____ Date: _____</p> <p>HIV Results <input type="checkbox"/> ELISA NR R <input type="checkbox"/> IFA NR R <input type="checkbox"/> WB NR R</p> <div style="border: 1px solid black; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;"> Place HIV Sticker Here </div>	
<p>CLINICAL IMPRESSION <input type="checkbox"/> No Disease Pending Results</p> <p><input type="checkbox"/> Bacterial Vaginosis <input type="checkbox"/> HSV First <input type="checkbox"/> BFP <input type="checkbox"/> HSV Recurrent <input type="checkbox"/> Chancroid <input type="checkbox"/> HPV Old Dx <input type="checkbox"/> Chlamydia-Cervix <input type="checkbox"/> HPV New Dx <input type="checkbox"/> Contact NGU/CT <input type="checkbox"/> Molluscum <input type="checkbox"/> Contact GC <input type="checkbox"/> MPC <input type="checkbox"/> Contact Syphilis <input type="checkbox"/> Non-STD Dermatitis <input type="checkbox"/> Contact Trich <input type="checkbox"/> PID NOS <input type="checkbox"/> Contact Other <input type="checkbox"/> PID CT <input type="checkbox"/> Crabs <input type="checkbox"/> PID GC <input type="checkbox"/> Folliculitis <input type="checkbox"/> Scabies <input type="checkbox"/> GUD-NOS <input type="checkbox"/> Syphilis 10 <input type="checkbox"/> GC Anal <input type="checkbox"/> Syphilis 20 <input type="checkbox"/> GC Cervical <input type="checkbox"/> Syphilis 30 <input type="checkbox"/> GC Pharynx <input type="checkbox"/> Syphilis 40 <input type="checkbox"/> GC Urethral <input type="checkbox"/> Syphilis 45 <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> Syph Pre Adeq Rxd <input type="checkbox"/> <input type="checkbox"/> Syphilis Other <input type="checkbox"/> Vaginitis Trich <input type="checkbox"/> Vaginitis Yeast <input type="checkbox"/> Other: _____</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>ALLERGIES</p> <input type="checkbox"/> None Known <input type="checkbox"/> Penicillin <input type="checkbox"/> Other _____ Rxn: _____</div>	<p>HEPATITIS B VACCINE IM</p> <p><input type="checkbox"/> 1st Dose <input type="checkbox"/> 2nd Dose <input type="checkbox"/> 3rd Dose</p> <p>Treatment <input type="checkbox"/> None</p> <p>Bicillin (IM) <input type="checkbox"/> 2.4 mu Only Series of 3 Injections <input type="checkbox"/> 1st 2.4 mu <input type="checkbox"/> 2nd 2.4 mu <input type="checkbox"/> 3rd 2.4 mu</p> <p><input type="checkbox"/> Ceftriaxone 250 mg IM X 1 <input type="checkbox"/> Spectinomycin 2 Gm IM X 1</p> <p><input type="checkbox"/> Azithromycin 1 GM PO X 1 <input type="checkbox"/> Cefixime 400 mg PO X 1 <input type="checkbox"/> Ofloxacin 400 mg PO X 1</p> <p><input type="checkbox"/> Metronidazole 500 mg PO <input type="checkbox"/> 2 gm PO X 1 Stat Dose <input type="checkbox"/> BID X 7 Days</p> <p><input type="checkbox"/> Cotrim 2 BID X 7 Days <input type="checkbox"/> Cotrim DS 1 BID X 3 Days</p> <p>Doxycycline 100 mg PO BID <input type="checkbox"/> 7 Days <input type="checkbox"/> 10 Days <input type="checkbox"/> 14 Days <input type="checkbox"/> 28 Days</p>	<p>HEPATITIS A VACCINE</p> <p><input type="checkbox"/> 1st Dose <input type="checkbox"/> 2nd Dose</p> <p>Erythromycin 250 mg PO QID <input type="checkbox"/> 7 Days <input type="checkbox"/> 10 Days</p> <p>Erythromycin 500 mg PO QID <input type="checkbox"/> 7 Days <input type="checkbox"/> 10 Days</p> <p>Wart Treatments <input type="checkbox"/> LN <input type="checkbox"/> TCA <input type="checkbox"/> Podophyllin</p> <p>Anti-Ectoparasitics <input type="checkbox"/> Permethrin Cream <input type="checkbox"/> Permethrin Rinse</p> <p>Anti-Fungal <input type="checkbox"/> Topical <input type="checkbox"/> Vaginal</p>	<p>WRITTEN RX</p> <p>Acyclovir 200mg 400mg 800mg Rx _____ Refills _____</p> <p>Valtrex 250mg 500mg Rx _____ Refills _____</p> <p>Famvir 125mg 250mg Rx _____ Refills _____</p> <p>Anti-Fungal <input type="checkbox"/> Oral _____ <input type="checkbox"/> Topical _____</p> <p>Aldara _____ Condylox _____</p> <p>Other _____</p>
<p>COMMENTS</p>			
<p>REFERRED TO:</p> <input type="checkbox"/> Primary Care <input type="checkbox"/> Emergency Room <input type="checkbox"/> PCM <input type="checkbox"/> Family Planning <input type="checkbox"/> CDI <input type="checkbox"/> Other _____	<p>COUNSELING:</p> <input type="checkbox"/> Medication <input type="checkbox"/> Condom <input type="checkbox"/> Results <input type="checkbox"/> Handouts <input type="checkbox"/> Temporary Abstinence <input type="checkbox"/> Partner Referral <input type="checkbox"/> Partner cards given	<p>FOLLOW-UP</p> <input type="checkbox"/> None/PRN <input type="checkbox"/> Re-Evaluate On: _____	

NP/PA: _____

RN: _____

MD: _____

HEPATITIS B CORE ANTIBODY (Anti-HBc) LAB TESTING

Policy:

To determine the baseline rate of past infection with hepatitis B for STD clinic patients the San Diego Hepatitis Project offered hepatitis B core antibody (Anti-HBc) testing to patients who routinely have blood drawn in the STD clinic (syphilis serology is routinely offered to all clients). Those specimens testing positive for Anti-HBc will also be tested for hepatitis B surface antigen (HbsAg).

Testing was done during the month of February 1998.

Procedure:

1. The clerk places a patient label on the copy of the **Examination for Hepatitis lab form**.
2. All patients having blood drawn in clinic for RPR or HIV are eligible to have hepatitis B core antibody testing done.
3. The nurse explains to each patient who is having blood drawn that hepatitis B core antibody testing can be done on the blood specimen if the patient agrees. The nurse explains that the testing is being offered for one month in conjunction with the availability of hepatitis B vaccine at the STD clinic.
4. If the patient agrees to have hepatitis B core antibody testing done, the nurse completes the Examination for Hepatitis lab form (Lab 22).
5. The nurse submits the lab form with the patient's blood specimen (only one tube of blood is needed for RPR or HIV and hepatitis B core antibody) to the Public Health Lab (PHL).
6. PHL will conduct hepatitis B core antibody test; all specimens reactive will then have additional testing done (HBsAG). All final results will be sent to the STD Clinic for posting in medical records; results should be given to the patient when they return or mailed if they have not returned within one month.

EXAMINATION FOR HEPATITIS

LAB NO.:

San Diego County Public Health Laboratory
3851 Rosecrans St. P.O. Box 85222
San Diego, CA 92186-5222 (619) 692-8500
C.R.Peter, Ph.D., Chief

CHECK TESTS REQUESTED:

HEP B

HEP C

(NON-IDU) HEP C EIA ONLY (IDU)

Patient Name & ID:

Zip Code:

Date of Birth:

Age:

Ethnicity:

Sex:

Date of Specimen:

Physician Name/Initials: _____ Phone: _____
Billing: Medi-Cal # _____ SOFP # _____ ICD-9 Code _____

SOURCE OF SPECIMEN: (Check only one)

Blood Serum Other (special study) _____

TYPE OF VISIT: (Check only one)

New Follow-up HIV Only Hep B vaccine #2/#3

REASON FOR VISIT/REFERRAL (Check only one)

Self Family Plan
 Hep B Vaccine Returnee Partner
 Outreach Worker CDI
 Drug Treatment Ctr. HIV ATS Counselor
 Other _____ MD/Health Clinic
 Unknown

KNOWN CONTACT (Check only one)

Hep B Hep C No Known Contact
 Other _____

RISK GROUP: (Check all that apply)

None IV Drug User Male-male
 Multiple (≥ 3 in 3 mos) Partners Sex Partner IVDU Bisexual
 Prostitute/Prostitute Contact Sex Partner Bisexual Man
 Blood Transfusion prior to 1992 Unknown

CLINIC SITE/ORIGIN OF REQUEST:

Rosecrans P-511D 001 North Coastal Region N-514 007 EIP/T-Cell
 Central Region S-516 003 South Region S-518 008 Epidemiology
 Alternative Test Site (Location) _____ Drug Court (Location) _____
 Methadone Clinic (Location) _____ Perinatal Hepatitis B
 Teen Mobile Clinic
 Other _____

DATE RECEIVED: