Ontario

Ministry of Community Safety and Correctional Services

Form 1 – Physician Report

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

OHIP Fee Code – K031

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 applicant must consent to examination, counselling, including counselling respecting prophylaxis or treatment, and baseline 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 baseline testing for the applicant in accordance with this form's instructions. You are not required to order baseline 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 Form 2 – 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.

For additional information, please visit http://www.mcscs.jus.gov.on.ca/english/about_min/MandatoryBloodTesting/blood_testing.html

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

A. Applicant Information

Collection of the information on this form is for the determination of an application under the *Mandatory Blood Testing Act, 2006*, 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 Policy Development and Coordination Branch, Ministry of Community Safety and Correctional Services at 416 212-4221.

Last Name	First Name	Middle Initial

Address

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code	Home Telephone	Business Telephone
	Ontario		( )	( )

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

Family Physician - *if Different from Reporting Physician*

Last Name	First Name	Middle Initial

Unit Number	Street Number	Street Name

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

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	Postal Code	Office Telephone	Office Fax Number
	Ontario		( )	( )

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	☐	yyyy/mm/dd		☐	☐
Known to be a carrier - HBs Ag positive	☐	yyyy/mm/dd		☐	☐
Known to be immune - Anti–HBs positive	☐	yyyy/mm/dd		☐	☐
Known to be HCV positive	☐	yyyy/mm/dd		☐	☐
Known to be HIV positive	☐	yyyy/mm/dd		☐	☐

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

Note to Physician:

*Applicant's baseline testing requisition is to be marked **"STAT".***

A copy of the applicant's baseline 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	☐	yyyy/mm/dd	
Hepatitis B surface antigen (HbsAg)	☐	yyyy/mm/dd	
Anti HBs	☐	yyyy/mm/dd	
Anti HCV	☐	yyyy/mm/dd	
Antibody to HIV	☐	yyyy/mm/dd	

G. Post-exposure Prophylaxis and Treatment	Yes	Date Commenced	N/A	Refused by Applicant
Hep B Vaccine	☐	yyyy/mm/dd	☐	
Hep B Immune Globulin (HBIG)	☐	yyyy/mm/dd	☐	
Post–exposure prophylaxis for HIV	☐	yyyy/mm/dd	☐	

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

Office Address

Unit Number	Street Number	Street Name

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

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 Blood-Borne Diseases Surveillance Protocol for Ontario Hospitals developed by the Ontario Hospital Association and Ontario Medical Association, 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)*