



Table 5: Instructions for Completion of Follow-Up Laboratory Testing Form (CDC 57.207)

This form should be completed for HCP who have additional laboratory testing done as a result of blood or body fluid exposures. These tests would occur after baseline laboratory testing had been completed.

♦ Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection																				
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.																				
Lab #	Required. The lab testing ID number will be auto-generated by the application.																				
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.																				
*HCW Name: Last, First, Middle	Optional. Enter the HCW's name.																				
*Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).																				
*Date of birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.																				
Exposure Event #	Required. The user is required to link the laboratory follow-up record to a blood and body fluid exposure record using the Link feature within the application. Once the exposure is selected and submitted, the form will display the message "Lab is Linked." Laboratory records must be linked to an exposure.																				
Lab Results																					
Lab Test	Required (At least one laboratory test and date are required). Multiple test results may be recorded on this form. Select lab test from dropdown menu: <table style="width: 100%; border: none;"> <tr> <td>HIV EIA</td> <td>ALT</td> </tr> <tr> <td>HIV confirmatory</td> <td>Amylase</td> </tr> <tr> <td>HepC anti-HCV EIA</td> <td>Blood glucose</td> </tr> <tr> <td>HepC anti-HCV-supp</td> <td>Hematocrit</td> </tr> <tr> <td>HepC PCR HCV RNA</td> <td>Hemoglobin</td> </tr> <tr> <td>HepB HBsAg</td> <td>Platelets</td> </tr> <tr> <td>HepB IgM anti-Hbc</td> <td>Blood cells in urine</td> </tr> <tr> <td>HepB Total anti-Hbc</td> <td>WBC</td> </tr> <tr> <td>HepB Anti-HBs</td> <td>Creatinine</td> </tr> <tr> <td></td> <td>Other</td> </tr> </table>	HIV EIA	ALT	HIV confirmatory	Amylase	HepC anti-HCV EIA	Blood glucose	HepC anti-HCV-supp	Hematocrit	HepC PCR HCV RNA	Hemoglobin	HepB HBsAg	Platelets	HepB IgM anti-Hbc	Blood cells in urine	HepB Total anti-Hbc	WBC	HepB Anti-HBs	Creatinine		Other
HIV EIA	ALT																				
HIV confirmatory	Amylase																				
HepC anti-HCV EIA	Blood glucose																				
HepC anti-HCV-supp	Hematocrit																				
HepC PCR HCV RNA	Hemoglobin																				
HepB HBsAg	Platelets																				
HepB IgM anti-Hbc	Blood cells in urine																				
HepB Total anti-Hbc	WBC																				
HepB Anti-HBs	Creatinine																				
	Other																				
Date	Required. Indicate date of test using mm/dd/yyyy format.																				
Result	Conditionally required. Select one of the result codes: Use codes: P= positive, N= negative, I=Indeterminate, U=Unknown, R=Refused)																				
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.																				
Comments	Optional. Enter any additional information about the HCW. CDC will not analyze this information.																				



Table 6. Instructions for Completion of the Healthcare Worker Prophylaxis/Treatment – Influenza Form (CDC 57.210)

This form should be completed when an HCW receives antiviral medications as influenza treatment or as chemoprophylaxis against influenza infection. It is used to collect information on which antiviral medications were administered, when, and what (if any) adverse reactions were experienced by the HCW.

*Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Med Admin ID #	Required. The medication administration ID number will be auto-generated by the application.
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.
*HCW Name: Last, First, Middle	Optional. Enter the HCW's name.
*Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
*Date of Birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
*Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. Location codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.
*Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. Occupation codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.
*Clinical Specialty	Conditionally required. If Occupation is physician, fellow or intern/resident, enter the appropriate clinical specialty. The list of clinical specialties can be found on Form CDC 57.204.
*Performs direct patient care	Required. Select Yes if the HCW provides direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment and monitoring); otherwise select No.
Infectious agent	Required. Auto-filled on hard copy form. Select Influenza in application.
For season	Required. Select the vaccination season. Specify the year(s) during which this chemoprophylaxis or treatment date falls. For NHSN purposes, the vaccination "season" is 7/1 of the first year to 6/30 of the next calendar year.
#	Required. Indicate up to 10 antiviral medications given using sequential numbers starting with 1.
Indication	Required. Select Prophylaxis or Treatment as appropriate.
Influenza subtype	Required. Select the influenza subtype for which the HCW is receiving antiviral medications (for post-exposure chemoprophylaxis or for treatment). Select Unknown, if you do not know the specific subtype necessitating antiviral medication use.
Antiviral medication	Required. Enter the code of the antiviral medication that was administered to the HCW using the codes listed at the bottom of the form.
Start date	Required. Enter the start date of the antiviral using mm/dd/yyyy format.
Stop date	Conditionally required. Enter the stop date of the antiviral using mm/dd/yyyy format.



Data Field	Instructions for Data Collection
Adverse reactions?	Required. Check Yes if the HCW had a severe adverse reaction attributable to the influenza antiviral medication; otherwise check No. If it is unknown whether or not the HCW experienced any adverse reactions, check Don't Know.
Adverse reactions to antiviral medication #1...#10	Conditionally required. If the HCW had a severe adverse reaction, check all reactions that apply for each medication administered. Please correlate the antiviral medication # with the antiviral medication on page 1. If an adverse reaction is not listed, check Other and specify the adverse reaction in the space provided. All Other adverse reactions should be included if the reactions were severe enough to affect daily activities and/or resulted in the discontinuation of the antiviral medication.
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information about the HCW. CDC will not analyze this information.