

Severity of Exposure:

How much fluid? _____

How long was exposure? _____

How severe was the injury? _____

Estimated time interval from exposure until medical evaluation: _____

Source of Exposure:

Source individual, if known: _____

Name

Address

Telephone

Is a blood sample from the source available? Yes No

Is the source individual's HBV antigen/antibody status known? Yes No

Is the source individual's HIV antibody status known? Yes No

Describe Activity Leading to Exposure:

Giving Injection

Recapping needle

Discarding needle

Handling IV line

Handling disposal box

Cleaning blood spill

Handling waste products

Handling lab specimen

Controlling bleeding

Performing invasive procedure

Other: _____

Precisely Describe Situation:

Describe immediate interventions:

Was the area washed flushed?

Other: _____

Did injury bleed freely? Yes No

Was antiseptic applied? Yes No

Describe nature and scope of personal injury, if any:

Was medical treatment obtained: Yes No

Hospital, physician or clinic where injured person was taken, if applicable:

Name

Address

Person completing form:

Name

Job title/occupation

Work telephone

Home telephone

Signature

Date

1. Risk of transmission associated with exposure.
2. Facts about Hepatitis B Virus and Human Immunodeficiency Virus.
3. Symptoms to report.
4. Recommendation for prevention of transmission (no donating blood, organs, sperm; no sex/safe sex; avoid pregnancy and breast feeding for recommended time).
5. Resources available for further counseling/information.
6. Information and recommendations about Human Immunodeficiency Virus antibody testing and Hepatitis B prophylaxis and testing.
7. Obtaining test reports.
8. Confidentiality.
9. Prevention of future exposures.
10. The right to consult a physician of choice for further follow-up counseling or for the purpose of obtaining information pertaining to current research or treatment that could be available.

HEPATITIS B EXPOSURE INFORMATION

You have been evaluated for exposure to Hepatitis B. Your treatment has been in accord with the SIUC Occupational Exposure Control Plan for exposure to Hepatitis B. Your risk of acquiring Hepatitis B has been minimized by this intervention. However, if you should develop any of the following signs or symptoms within six months of exposure, please call the SIU-SM Infection Control Nurse (545-8970) or the Infection Control Physician on duty (545-5880).

1. Jaundice (yellowing of the skin and/or eyes)
2. Fever (greater than 101°F or 38.2°C)
3. Anorexia (loss of appetite)
4. Fatigue, malaise or lassitude (feeling tired for an extended period)
5. Nausea or vomiting
6. Diarrhea
7. Joint pain
8. Right upper abdomen or epigastric pain
9. Myalgia (sore muscles)

Date of Exposure: _____

Signature: _____

Employee I.D. #: _____

Printed Name: _____

Witness: _____



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BLOODBORNE PATHOGEN EXPOSURE INCIDENT HEALTHCARE PROFESSIONAL'S WRITTEN OPINION

HBV Vaccination indicated? Yes No

HBV Vaccination received? Yes No Date Received: _____

On _____, _____ was evaluated by SIU-SM Infection
Date Name

Control personnel, following an occupational exposure to human blood or other potentially infectious materials. He/she has been informed of the results of the post-exposure evaluation and has been advised of any medical conditions resulting from the exposure incident that require further evaluation or treatment.

Signature

Job Title

Date

SOURCE PATIENT INFORMATION

Source Name: _____

Work Phone: _____ Home Phone: _____

Address: _____

Medical Record #: _____ Room #: _____ Hospital: _____

Date of Birth: _____ Primary Care/Attending Physician: _____

Diagnosis: _____

Source Risk Factors (as documented in medical record or patient interview):

- Yes No Unknown Known HIV Positive
- Yes No Unknown Known homosexual, bisexual, prostitute, or sexual contact with same
- Yes No Unknown Known IV drug user or history of same
- Yes No Unknown Received blood transfusion 1977 – 1985
- Yes No Unknown Currently taking Zidovudine (AZT), Lamiduvine (3TC), and/or Indinivir (IDV)
- Yes No Unknown History of Hepatitis B, past, present or carrier
- Yes No Unknown History of Hepatitis C, past, present or carrier
- Yes No Unknown History of hemophilia, kidney, dialysis, transplant
- Yes No Unknown Currently elevated liver enzymes
- Yes No Unknown Current fever, lymphadenopathy, rash, malaise, GI or neuro symptoms
- Yes No Unknown Traveled outside of the United States

If yes, when and to which countries: _____

Signature of individual preparing form

Date