BLOODBORNE PATHOGENS EXPOSURE REPORT

In case of exposure to bloodborne pathogens, complete this form and return to the Infection Control Nurse within 24 hours for post-exposure evaluation. If other persons were involved, attach additional copies of this form for each person involved.

Date of Report: _____/_____/_____ Time of Report: ______________________________

Name (Last, First, M.I.): ____

Sex: ☐ Male ☐ Female Employee I.D. Number: ________________________

Address (Local): _______________________________ Date of Birth: ________________________________

Work Phone: __________________________________ Home Phone: ________________________________

Status at time of exposure: ☐ Employee ☐ Student ☐ Faculty ☐ Other: ______________________________
(Explain)

Job Title: _____________________________________ Duties related to exposure: ____________________

____

Has the exposed individual been immunized against hepatitis B Virus? ☐ Yes ☐ No

Dates of Immunization: (1) _____/_____/_____ (2) _____/_____/_____ (3) _____/_____/_____

Place where exposure incident occurred:

____

Department Work Area Date Time

Did incident arise out of and in the course of University employment? ☐ Yes ☐ No

Name of individual in charge of area where exposure occurred: ____

List any witnesses present: ____
Name Address Telephone

____
Name Address Telephone

Personal protective equipment in use at time of exposure: ____

Exposure to:

☐ Blood
☐ Body fluid with visible blood
☐ Vaginal secretions
☐ Seminal fluid
☐ Internal body fluids (circle one) cerebrospinal, synovial, pleural, amniotic, pericardial, peritoneal

Type of Exposure:

☐ Needlestick/sharps accident Device Type: _____________________ Device Brand: _____________________
☐ Contact with mucous membranes (eyes, mouth, nose)
☐ Contact with skin (circle all that apply) broken, chapped, abraded, dermatitis, prolonged contact, extensive contact

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

COUNSELING CHECKLIST FOR BLOOD AND/OR BODY FLUID EXPOSURE

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^{o}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: ____

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, lympyhadenopathy, 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