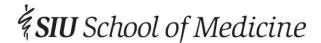


BLOODBORNE PATHOGENS EXPOSURE REPORT

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: (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: Work Area Department Date 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 Address Telephone Name Personal protective equipment in use at time of exposure: Exposure to: Blood Seminal fluid Body fluid with visible blood Internal body fluids (circle one) cerebrospinal, ☐ Vaginal secretions 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

Signature		Date	
Name	Job title/occupation	Work te lephone	e Home telephone
r crson completing form.			
Person completing form:	11441055		
Name	Address		
Hospital, physician or clinic when	re injured person was taken, if	applicable:	
Was medical treatment obtained:	Yes No		
Describe nature and scope of pers	sonal injury, if any:		
Was the area ☐ washed ☐ flus. Did injury bleed freely? ☐ Yes Was antiseptic applied? ☐ Yes	□No		
Describe immediate interventions	<u>s</u> :		
Precisely Describe Situation:			
Cleaning blood spill			
Handling IV line Handling disposal box		Performing invasive p Other:	
Discarding needle		Controlling bleeding	
☐ Giving Injection☐ Recapping needle		☐ Handling waste produ☐ Handling lab specime	
Describe Activity Leading to Exp	oosure:		
Is a blood sample from the source Is the source individual's HBV at Is the source individual's HIV an	ntigen/antibody status known?		
Nam	ne		Telephone
Source individual, if known:			
Source of Exposure:	osure until medical evaluation	•	
Estimated time interval from exp			
How long was exposure? How severe was the injury?			
How much fluid?			



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.

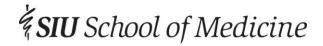


HEPATITIS B EXPOSURE INFORMATION

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°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 indicat	ted? Yes No	
HBV Vaccination receive	ed? Yes No Date	Received:
On, _	Name	was evaluated by SIU-SM Infection
Control personnel, follow		re to human blood or other potentially infectious
materials. He/she has bee	en informed of the results of	the post-exposure evaluation and has been advised
of any medical conditions	s resulting from the exposure	e incident that require further evaluation or
treatment.		
Signature	Job T	Title Date

SOURCE PATIENT INFORMATION

Source Name:				
Work Phone:	Phone: Home Phone:			
Address:				
Medical Record #:	Room #: Hospital:			
Date of Birth:	Primary Care/Attending Physician:			
Diagnosis:				
Source Risk Factors (as documen	ated 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			