BLOODBORNE PATHOGENS EXPOSURE REPORT

Southern Illinois University at Carbondale

In case of exposure to bloodborne pathogen(s), complete this form and return to the Center for Environmental Health and Safety within 24 hours. A copy must be taken to the SIUC Health Service or other healthcare provider 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: ☐ M ☐ F SSN Last Four:_____

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: 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:

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

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Type of Exposure:

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

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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's name, if known: _____
Address: _____ Phone: _____
Is a blood sample from the source available? _____
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 needles
☐ Discarding needles
☐ Handling IV lines
☐ Handling disposal box
☐ Other: _____
☐ Cleaning blood spills
☐ Handling waste products
☐ Handling lab specimens
☐ Controlling bleeding
☐ Performing invasive procedure

Describe Situation Precisely: _____
_____

Describe Immediate Interventions:

Was the area ☐ washed ☐ flushed?
Did injury bleed freely? ☐ yes ☐ no
Was antiseptic applied? ☐ yes ☐ no
Other: _____

Describe nature and scope of personal injury, if any:

Was medical treatment obtained?
☐ yes ☐ no

Name and address of hospital, physician or clinic where injured person was taken, if applicable:

Name of person completing form: Job title/occupation:

Signature: Work Phone Number: Date:
Home Phone Number:

Attachment 3, OECP, SIUC 2018

EMPLOYEE CONSENT FOR HIV ANTIBODY TEST

Because I have been exposed to another individual's blood and/or body fluid, it has been recommended that I have a blood test to detect whether I have antibodies to the Human Immunodeficiency Virus (HIV or the AIDS virus) or to Hepatitis B. I understand that this test is performed by withdrawing a sample of my blood and then testing that blood.

I further understand that a positive blood test result for HIV does not mean that I have AIDS, but that my blood has been exposed to the AIDS virus and antibodies to that virus are present in my blood. I understand that in the event of a positive test result there are other recommended confirmatory tests that are available if I do so desire.

I have also been informed and understand that the test results, in a percentage of cases, may indicate that a person has antibodies to the virus when the person does not (a false positive result) or that the test may fail to detect that a person has antibodies to the virus when the person does in fact have these antibodies (a false negative result).

I understand that I have the right to anonymity in the test, if requested. I understand that if there is a positive test result, such result must be reported to the Department of Public Health. I further understand that no additional release of the results will be made without my written authorization and the results will be kept confidential to the extent provided by law.

I understand that I am to be tested at the time of exposure and tested again at 6 weeks, 3 months, 6 months and 12 months after exposure.

I understand that I may withdraw from the testing at any point in time prior to the completion of laboratory tests, and I hereby state that my agreement to be tested is voluntary on my part and has not been obtained through any undue inducement, threat, or coercion.

It is with the above understanding that I hereby give my consent to the testing of my blood.

Date:_____

Signature:_____

SSN Last 4 Digits_____

Print Name:_____

Witness:_____

I decline testing:

Date:_____
Signature:_____
SSN Last 4 Digits_____
Print Name:_____