FORM 1: SUPERVISOR’S FOLLOW-UP REPORT OF INCIDENT

Supervisor to Complete:

Name of Employee or Client: _____________________________________________

Days lost from work? □ Yes □ No Number of days: _______________________

Work restrictions: □ Yes □ No Specify: ________________________________

Describe in detail what employee/client was doing when accident/injury occurred (to the
best of your knowledge): ___________________________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Specify part of body affected and how affected: _________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Explain in detail how and why this accident/injury occurred: ______________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
List action(s) taken to prevent similar accidents/injuries from occurring: ____________

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

A preventable accident/injury is one in which the employee/client failed to do everything within reason to prevent it from occurring.

In your opinion was this a ☐ preventable or ☐ non-preventable accident by the employee/client?

Please explain: ___________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Signature of Supervisor who conducted the investigation __________________________ Date ______________________

Affected Employee to Complete:

I have read the above and received a copy of the “Incident Report” and this “Supervisor’s Follow-up Report of Incident” (if requested).

Additional Comments: ___________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Signature of Affected Employee __________________________ Date ______________________
FORM 2: EXPOSURE CONTROL TEAM ASSESSMENT & REPORT OF POSSIBLE BLOODBORNE PATHOGEN EXPOSURE

To be completed jointly by the Exposure Control Team and the affected HCW

I. INCIDENT INFORMATION (this section to be completed by the affected HCW)

Name of Affected HCW: __________________________ Date of Birth: ______________

Date and time of incident: __________ Location of incident: ______________________

What procedure was being performed? __________________________

At what site and how did the exposure occur? __________________________

If the exposure was related to a sharp device, what device was used? ______________

   Type: __________________________ Brand: __________________________

For a needlestick exposure:

   Was this a needle that had been used in a vein or artery? ______________

   What was the gauge of the needle? __________________________

   What was the estimated depth of the injury? __________________________

   Was fluid injected? __________ If yes, estimate the volume: ______________

For mucous membrane or non-intact skin exposure:

   Estimate the volume of material that splashed you: __________________________

   Describe the condition of your mucous membrane or skin at the site of exposure
   (e.g., chapped, abraded, intact): __________________________

II. INCIDENT CLASSIFICATION (to be completed by Exposure Control Team)

Date & Time of Evaluation: __________________________

Name of Exposure Control Team Member managing the HCW: _______________________

Does the incident described above represent a definite or possible exposure to one or more blood or body fluid pathogens (refer to Table 1 for assistance with this determination)? ☐ Yes ☐ No

If Yes, complete this form and proceed with evaluation of HCW for PEP for the
pathogen(s). If this incident does NOT represent an exposure to blood or body fluid
pathogens, PEP is not warranted; however, complete section III below and update
hepatitis B and tetanus vaccination status as needed.
### III. HEALTH CARE WORKER INFORMATION
(to be completed jointly by the affected HCW and the Exposure Control Team)

<table>
<thead>
<tr>
<th>Hepatitis B vaccination (circle one):</th>
<th>Full series</th>
<th>Partial series</th>
<th>None</th>
</tr>
</thead>
</table>

Status of Response to Hepatitis B Vaccine (date of test):

History of chronic Hepatitis B? (Date of Diagnosis)

History of chronic Hepatitis C? (Date of Diagnosis)

History of HIV infection? (Date of Diagnosis)

Allergies to Medications:

Last Td booster:

HCW medical history & current medical conditions:

Baseline HBVsAb, HBsAg, HCV Ab, HIV Ab labs drawn: □ Yes □ No

If starting Antiretroviral PEP Medications, CBC, BUN, Cr, ALT drawn: □ Yes □ No

### IV: RELEVANT SOURCE PATIENT INFORMATION
(to be completed by the Exposure Control Team). *Note: Attempts to gather this information should not delay decision-making on PEP. If information on the source patient is not immediately available, proceed to the next section and administer PEP if indicated. Additional information on the source patient can be considered at the 72 hour follow-up visit.*

Source patient name:  
Chart number:  

Diagnosis(es):

History of Hepatitis B?  
Hepatitis C?  
HIV?  
Abnormal ALT/AST?  
History of transfusion before 1985?  
High-risk sexual behavior?  
Injection drug user?  
If the source patient is HIV-infected, please provide the following information if known:

Stage of HIV disease:  

History of antiretroviral therapy (if any):  

Last CD4 count, with date:  

Last HIV RNA (viral load), with date:  

Antiretroviral resistance information (if known):  

Any other information that may be relevant:  

V. EXPOSURE CONTROL TEAM PEP RECOMMENDATIONS, BY PATHOGEN  

(To be completed by Exposure Control Team. See Tables 1-4 for assistance.)

HBV:  

HCV:  

HIV:  

Td Booster indicated?  □ Yes  □ No

Does the HCW agree with these recommendations?  □ Yes  □ No

If not, describe plans of the HCW for PEP:  

COMMENTS/NOTES/PEPLINE ADVICE:  

FORM 3: INFORMED REFUSAL OF MEDICAL EVALUATION FOLLOWING EXPOSURE TO BLOODBORNE PATHOGEN(S)

I, ____________________________________________, am employed by ________________________________________________________

On (date) ________________, I was involved in the following exposure incident (describe incident):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

My employer has offered to provide follow-up medical evaluation for me in order to ensure that I have full knowledge of whether I have been exposed to or contracted an infectious disease from this incident.

However, of my own free will and volition and despite my employer's offer, I have elected not to have a medical evaluation or treatment for this bloodborne pathogen exposure.

Name (Print): ____________________________________________________________

Signature: ________________________________________________________________

Witness Signature: _________________________________________________________

NOTE: Maintain in this office for duration of employment plus 30 years.
FORM 4: EMPLOYEE REFUSAL TO RECEIVE HEPATITIS B VACCINATION

STATEMENT

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine.

However, I decline hepatitis B vaccine at this time. I understand that by declining this vaccine, I may continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Name (Print): ________________________________

Signature: ________________________________

Date: ________________________________

Employer: ________________________________

Witness: ________________________________
FORM 5: LACK OF DOCUMENTATION OF HEPATITIS B VACCINATION AND REFUSAL OF EVALUATION FOR IMMUNITY

I hereby testify that I have received the complete hepatitis B (HBV) vaccination series. To the best of my knowledge, I received the final injection on or about:

Date: ______________________

However, I cannot offer documented proof of this to my employer.

Since no proof of vaccination is available, I understand that it is my right to request a test to show whether or not I have antibodies to HBV, and that if this antibody test reveals an insufficiently high titer to document immunity to HBV, I may choose to have either a booster vaccination or repeat the entire HBV vaccination series at no cost to me.

At the present time, I refuse to submit to such a test, but reserve the right to request the test at a future date.

Name (Print): ________________________________

Signature: ________________________________

Date: ________________________________

Employer: ________________________________

Witness: ________________________________
FORM 6:  CONSENT FOR HIV TEST

To be signed by HCW prior to baseline HIV antibody testing

I have been informed that my blood will be tested in order to detect whether or not I have antibodies to the Human Immunodeficiency Virus (HIV), which is the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood and then testing the blood for antibodies to HIV.

I have been informed that the test result may rarely be falsely positive (i.e., suggest that a person is infected with HIV when in fact that person is not infected with HIV), or it may rarely be falsely negative (i.e., suggest that a person is not infected with HIV when in fact that person is infected with HIV). I understand that HIV infection does not necessarily imply AIDS, the diagnosis of which requires other clinical and laboratory evidence in conjunction with this blood test.

I have been informed that if I have any questions regarding the nature of the blood test, the potential benefits & risks associated with testing, or alternatives to the test, I may ask those questions before I decide to consent to the test.

I understand that the results of the test are confidential and will only be released to those health care practitioners directly responsible for my care and treatment and to others as required by law. I further understand that no additional release of the results will be made without my written authorization.

By my signature below, I acknowledge that I have been given all the information I desire concerning the blood test and release of its results, and that all of my questions about the test have been answered. I hereby state my consent for the performance of test on my blood to detect evidence of infection with the Human Immunodeficiency Virus (HIV).

Name (Print):  _________________________________________________________________

Signed:  _________________________________________________________________

If signed by other than the patient, indicate relationship:  _________________________

Date:  __________________________
FORM 7: INCIDENT REPORT

Affected Health Care Worker to complete, with Supervisor Signature at bottom

Name: ____________________________________________________________
Date of birth: ____________ Gender: ___ Marital Status: ___ No. Dependents: ___
Parent/Guardian (if applicable): __________________________________________
Location of incident (specific address): ___________________________________
Date and time of incident: ______________________________________________
(Day of week) (Date) (Time, a.m. or p.m.)
Did you return to work during the next scheduled shift? □ Yes □ No
If “No,” will wage loss exceed six work days? □ Yes □ No □ Not sure
Date of return, if returned to work ________________
Description of incident: ________________________________________________
____________________________________________________________________
Specify part of body affected and how affected: ____________________________
____________________________________________________________________
Names of witness(es) to the incident: ______________________________________
____________________________________________________________________
Intervention/Attending Physician's name/address/phone number: ______________
____________________________________________________________________
Outcome: __________________________________________________________________
____________________________________________________________________
First reported to: ______________________________________________________
Name, Position, Date

Signature of Employee Position Date
__________________________________________
Signature of Supervisor Position Date
__________________________________________

Check all that apply:
Received Medical Treatment: □ Yes □ No
Given Work Restrictions: □ Yes □ No
Absence from work: □ Yes □ No

HUMAN RESOURCES USE ONLY

Workers’ Comp Claim Filed: □ Yes □ No □ N/A Signature: ________________ Date: ______
FORM 8: SHARPS INJURY LOG

To be completed by exposed employee, with additional signatures at bottom

Name: ________________________________  Date: __________
Job classification: _______________________  Program: _______
Source patient: ____________________________
Date and time of exposure: ____________________________
Procedure being performed: ____________________________
Instrument being used: ___________  Brand: _______  Size: ______
Describe the incident: ____________________________

Was a safety device used?  Yes  No
  If “Yes,” was the safety feature activated?  Yes  No
Did the injury occur before or after activation of protective mechanism?  Yes  No
If a safety device were not used, could a safety device have prevented the injury?  
  Yes  No
  If “Yes,” how: ____________________________

Could any of the following controls have prevented the injury? Describe how.
  Engineering control ____________________________
  Administrative control ____________________________
  Work Practice control ____________________________

Signatures: ____________________________  Date: __________
Exposed Employee: ____________________________  __________
Supervisor: ____________________________  __________
Safety Director: ____________________________  __________
FORM 9: SEVENTY-TWO HOUR FOLLOW-UP VISIT

HCW Name: ___________________________ Date of Exposure: ______________
Managing Clinician: _______________________ Date: ______________________

I. Record PEP interventions that were made at initial visit (if any), HCW adherence to these recommendations, and any HCW concerns regarding these recommendations:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

II. Record any new information that may have become available about the Source Patient or the exposure since the initial evaluation:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

III. Record baseline laboratory studies performed on HCW at the initial visit:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

IV. List changes, if any, to PEP recommendations made at initial visit, including any interventions performed today (e.g., vaccinations, new medications, etc.):

1. HIV: ____________________________________________
2. HBV: ___________________________________________
3. HCV: ___________________________________________
4. Other interventions or changes performed today: ______________________

________________________________________________________________________

V. List indicated vaccinations, blood tests, and follow-up visits (check box if indicated):

☐ Hepatitis B vaccine #2 in 1 month on ________________
☐ Hepatitis B vaccine #3 in 6 months on ________________
☐ Hepatitis B immune globulin (HBIG)\(^1\) in 1 month on ________________
☐ Return visit in 2 weeks (if on antiretroviral therapy for HIV PEP) on

☐ Repeat HIV antibody testing in
  o 6 weeks on ________________
  o 3 months on ________________
  o 6 months on ________________

☐ Repeat Anti-HCV antibodies and ALT in 6 months on ________________
☐ If source patient is HCV+ with documented viral load, consider HCV Viral Load at 6 week follow-up on ________________

\(^1\) A 2\(^{nd}\) dose of HBIG one month later is indicated only in the very rare scenario of an exposure to a source patient with known or suspected chronic HBV infection involving a HCW who is a known non-responder to two HBV vaccination series (see Table 3 from CDC Guidelines: MMWR 2001 Vol 50 No. RR-11).
FORM 10: HEALTH CARE WORKER WRITTEN OPINION

NOTE: The Healthcare Worker’s Written Opinion must be completed and given to employee within 15 days after the completion of the evaluation.

Date: ____________________________

Employee Name: ____________________________  SSN: ____________________________
Provider Signature: ____________________________________________________________

NOTE: Information concerning the source individual’s HIV, HBV, or HCV status must be treated as confidential.

1. The employee has been informed of the results of the evaluation
On date: ____________________________  by whom: ____________________________

2. The employee has been told about any medical conditions resulting from exposure to blood or other infectious diseases which require further evaluation or treatment (see Summary of Bloodborne Diseases on next page)
On date: ____________________________  by whom: ____________________________

Original to employee
CC: Employer
CC: Employee Record/CHC Chart
SUMMARY OF BLOODBORNE DISEASES

Acquisition of bloodborne pathogens, most commonly via percutaneous injury with a contaminated needle, is a major concern to health care workers. More than 20 diseases have been transmitted in the hospital setting by needle sticks including HIV, hepatitis B, hepatitis C, syphilis, and malaria.

Prevention of transmission in the hospital setting of these agents requires strict adherence to universal blood and body fluid precautions, use of proper techniques for obtaining blood and disposing of needles and sharps, and immunization of hospital personnel with significant exposure to blood or body fluids with hepatitis B vaccine.

<table>
<thead>
<tr>
<th>DISEASES THAT CAN BE TRANSMITTED BY BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS</th>
<th>OTHER POTENTIALLY INFECTIOUS MATERIALS THAT MAY CONTAIN BLOODBORNE PATHOGENS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B Virus (HBV)</td>
<td>Semen</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus (HIV)</td>
<td>Vaginal secretions</td>
</tr>
<tr>
<td>Hepatitis C Virus (HCV)</td>
<td>Cerebrospinal fluid</td>
</tr>
<tr>
<td>Delta Hepatitis</td>
<td>Synovial fluid</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Pleural fluid</td>
</tr>
<tr>
<td>Malaria</td>
<td>Pericardial fluid</td>
</tr>
<tr>
<td>Babesiosis</td>
<td>Peritoneal fluid</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>Amniotic fluid</td>
</tr>
<tr>
<td>Leptospirosis</td>
<td>Saliva in dental procedures</td>
</tr>
<tr>
<td>Arboviral Infections</td>
<td>Any body fluid visibly contaminated with blood</td>
</tr>
<tr>
<td>Relapsing Fever</td>
<td>Any unfixed tissue or organ from a human</td>
</tr>
<tr>
<td>Creutzfeldt-Jakob Disease</td>
<td>HIV- or HBV-containing cell, tissue, or organ cultures; and culture medium</td>
</tr>
<tr>
<td>Human T-Lymphotrophic Virus Type 1</td>
<td>Blood, organs, or other tissues from HIV- or HBV-infected experimental animals</td>
</tr>
<tr>
<td>Cytomegalovirus (CMV)</td>
<td></td>
</tr>
</tbody>
</table>

Source U S Department of Labor (1989)
FORM 11: TWO WEEK FOLLOW-UP VISIT: RECOMMENDATIONS FOR HCW

To be completed by the managing clinician; copy to HCW after completed

HCW Name: ___________________________ Date of Birth: __________________
Managing Clinician: ____________________ Date/Time: ___________________

I. Record PEP interventions made to date, including the HIV PEP regimen that was prescribed, HCW adherence to these recommendations, and any HCW concerns regarding these recommendations:

_____________________________________________________________________
_____________________________________________________________________

II. Record any new information that may have become available about the source patient or the exposure since the last evaluation:

_____________________________________________________________________
_____________________________________________________________________

III. Record any laboratory studies performed on HCW since the exposure:

_____________________________________________________________________

IV. List changes, if any, to HIV PEP recommendations made at prior visits, and any other interventions performed or recommended today (e.g., vaccinations, referrals, etc.):

_____________________________________________________________________

V. Reminders to HCW regarding follow-up blood tests and vaccinations (check box if indicated):

☐ Hepatitis B vaccine #2 on _____________
☐ Hepatitis B vaccine #3 on _____________
☐ Hepatitis B immune globulin (HBIG)¹ on _____________
☐ Repeat HIV antibody testing at
  o 6 weeks on ________________
  o 3 months on ________________
  o 6 months on ________________
☐ Repeat Anti-HCV antibodies and ALT on ________________

¹ A 2nd dose of HBIG one month later is indicated only in the very rare scenario of an exposure to a source patient with known or suspected chronic HBV infection involving a HCW who is a known non-responder to two HBV vaccination series (see Table 3 from CDC Guidelines: MMWR 2001 Vol 50 No. RR-11).
FORM 12: SIX WEEK FOLLOW-UP VISIT: RECOMMENDATIONS FOR HCW

To be completed by the managing clinician; copy to HCW after completed

HCW Name: ___________________________ Date of Birth: ________________
Managing Clinician: ___________________ Date/Time: ________________

I. Record adherence with PEP regimen, total duration of PEP completed, and any side effects that have persisted:
   ____________________________________________________________
   ____________________________________________________________

II. Record any immunizations or laboratory studies performed on HCW since the exposure:
   ____________________________________________________________
   ____________________________________________________________

III. Perform HIV antibody test:
   ____________________________________________________________

IV. Consider Performing HCV antibody test:
   ____________________________________________________________

V. Reminders to HCW regarding follow-up blood tests and vaccinations (check box if indicated):
   ☐ Hepatitis B vaccine #3 on ________________
   ☐ Repeat HIV antibody testing at
     o 3 months on ________________ and
     o 6 months on ________________
   ☐ Repeat Anti-HCV antibodies and ALT on ________________
FORM 13: TWELVE WEEK FOLLOW-UP VISIT: RECOMMENDATIONS FOR HCW

To be completed by the managing clinician; copy to HCW after completed

HCW Name: ____________________________  Date of Birth: ______________________
Managing Clinician: ____________________  Date/Time: _________________________

I. Record any immunizations or laboratory studies performed on HCW since the exposure:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

II. Perform HIV antibody test:
    __________________________________________________________

IV. Consider HCV antibody test and consider testing for HCV RNA if earlier diagnosis of HCV is desired:
    __________________________________________________________

V. Reminders to HCW regarding follow-up blood tests and vaccinations (check box if indicated):
   □ Hepatitis B vaccine #3 on _____________
   □ Repeat HIV antibody testing at
      ○ 6 months on ________________
   □ Repeat Anti-HCV antibodies and ALT on ________________
FORM 14: TWENTY-FOUR WEEK FOLLOW-UP VISIT: RECOMMENDATIONS FOR HCW

To be completed by the managing clinician; copy to HCW after completed

HCW Name: ___________________________ Date of Birth: ___________________
Managing Clinician: ___________________ Date/Time: ___________________

I. Record any immunizations or laboratory studies performed on HCW since the exposure:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

II. Perform HIV antibody test:

________________________________________________________________________

IV. Perform HCV antibody test:

________________________________________________________________________

V. If patient receiving hepatitis B vaccine series, give 3rd dose:

________________________________________________________________________