Exposure Report Form

Patient Information:

Name: _____ Sex: _____ Age: _____ Phone #: _____

Exposure Information: _____ Blood-borne _____ Airborne

Exposed to:

___ Blood ___Bloody Fluid
Other _____

Area Exposed:

___Hands ___Nose
___Face ___Mouth
___ Eyes Other _____

Personal Protective Equipment used? ___No ___Yes Type _____

Task being performed at exposure? _____

Needle Safe Device Used? ___No ___Yes ___N/A

Employee Information:

Name: _____ SSN: _____

Phone (W): _____ Phone (C):_____

Exposure Date: _____ Time: _____

Location: _____ Reported to: _____

First-Aid Performed? ___No ___Yes

Source Patient Blood Drawn: ___No ___Yes Where? _____

Reporting Process:

Supervisor Notified: ___No ___Yes Name: _____

Date: _____ Time: _____

Designated Officer Notified: ___No ___Yes Name: _____

Date:_____ Time: _____

Post-Exposure Follow-Up:

Employee Given Source Patient Test Results: ___ No ___Yes Date: _____ Time:_____

Employee Medical Follow Up Referral to: _____

A written, signed explanation of how the exposure event occurred must be attached within 24 hours of the incident. This is to be sent to the Designated Officer(s).

Description of Exposure Event:

Member Signature: _____

Date: _____