University of South Dakota Health Affairs
OCCUPATIONAL EXPOSURE TO PATHOGENS OF EPIDEMIOLOGICAL IMPORTANCE
REPORT FORM

Student __________________________ Course & Campus __________________________

Student’s phone number __________________________

Program: Addiction Studies □; Dental Hygiene □; Health Science □; Medical Laboratory Science □;
Medical □; Nursing □; Physical Therapy □; Physician Assistant □; Occupational Therapy □;
Social Work □; Master of Social Work □; Master of Public Health □

Date of report ___________ Date of exposure ___________ Time of exposure ___________

Hospital/Clinic site where exposure occurred __________________________________________________

City __________________________ Supervisor/Faculty __________________________

Details of Exposure: To be Completed by the Student

Details of the occurrence/procedure being performed; including where and how the exposure occurred ___________

Type of exposure: puncture- □; scratch- □; bite- □; nonintact skin- □; mucous membrane of: eye- □;
nose- □; mouth- □; other type of exposure (describe) ____________________________________________

Extent of exposure (type and amount of blood/body fluid/material, severity of exposure including depth and whether fluid was
injected, etc.) ________________________________________________________________

PPE (personal protective equipment) worn: gloves- □; gown- □; mask- □; protective eyewear- □;
face shield□; other PPE (describe): ____________________________________________

If related to a sharp device: needle type: suture □ injection □ IV needle □ scalpel □ instrument □
brand name of device: ___________________________________________________________________
other sharp device (describe): ___________________________________________________________________

Decontamination (i.e. hand washing, flushing mucous membrane eye, nose, mouth, etc.) ___________

Description of first aid administered ________________________________________________________

Is it possible the patient was exposed to your blood? YES NO (circle one)

Who was the exposure incident reported to at the facility? ______________________________________

Date Reported: ________________ Contact information _______________________________________

I consent to the release of information such as immunization and immunity status and serology test results both to and from
the clinical site providing my post-exposure counseling and management.

Student's signature: __________________________ Date: ________________

12/22/2016
Post Exposure Management

Student’s Information

Student name __________________________________________ Date of exposure ______________

Medical person completing post exposure management __________________________________________

Date of last tetanus booster: ____________________________

Hepatitis B immunity status:
Series completed: yes ☐ no ☐
Post immunization titer (HBsAb): positive ☐ negative ☐ unknown ☐

Post exposure testing of student completed:
HIV yes ☐ no ☐ student drawn but declined HIV testing; blood will be stored for 90 days from incident ☐
HCV Ab yes ☐ no ☐
HBsAb yes ☐ no ☐ not tested (known immunity) ☐

Source Patient’s Information

Was the source patient identifiable? Yes ☐ No ☐

Source patient was tested for:
HIV (30 min) date drawn____________ not tested ☐ written copy of results given to student ☐ date received____________
HCV Ab date drawn____________ not tested ☐ written copy of results given to student ☐ date received____________
HBsAg date drawn____________ not tested ☐ written copy of results given to student ☐ date received____________

Other tests performed: ______________________________________________________________________________________

☐ HIV Prophylaxis offered to the student; date started _______________ ☐ HBIG indicated; date given ______________

Post Exposure Health Evaluation and Written Opinion

The above named student has reported an occupational exposure incident to blood or other potentially infectious material to: Facility name __________________________________
Address __________________________ Phone # _________________________

☐ Student was informed of the results of the post exposure evaluation,

☐ Counseling was provided regarding the mode & risk of transmission of blood borne pathogens relative to the exposure incident. Follow up evaluation & treatment indications, including prophylaxis, for the student were discussed.

☐ Student has been informed of any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

☐ HIV & Hepatitis C Ab recommended at baseline ☐ Follow up lab work is recommended on ______________

Hepatitis B vaccination: ☐ is indicated ☐ is not indicated ☐ Other lab work (specify) is recommended on ______________

☐ Follow-up health appointment is recommended on ______________

☐ Precautions to prevent transmission of a blood borne illness were recommended to the student during the follow-up period.

☐ The importance of maintaining confidentiality of the source patient’s identity and test results was discussed with the student.

Date of Health Evaluation______________ ☐ Copy of written opinion given to student; date ________________
(provide within 15 days of completing health evaluation)

Name/title of Medical Provider __________________________________________
Signature __________________________________________
Printed name __________________________________________

Please return a copy of the exposure report, post exposure management, evaluation and written opinion to the Education Coordinator in your program

12/22/2016