Post-Exposure Evaluation and Follow-up

The Bloodborne Pathogens regulation requires that the employer provide a post exposure evaluation and follow-up to an employee who has experienced an exposure incident.

It is very important that the following instructions are thoroughly read and your responsibilities understood. You are required to maintain information in this packet for thirty (30) years beyond the employee's last day of employment. Therefore, material in this packet must be completed accurately and thoroughly by all persons involved.

Medical Providers: Your participation and assistance in our compliance efforts are greatly appreciated. Thank you in advance for completing and remitting the appropriate forms contained in this packet.

As stated in the written exposure control plan, the employee is responsible for immediately reporting a possible exposure incident to his/her supervisor. Post exposure evaluations and follow-up procedures are in the best interests of an employee who has been potentially exposed. By law, the evaluation and any follow-up procedures must be available for the employee at a reasonable time and place.

Important Information

The documents below must be taken by your exposed employee and the source patient to the medical facility at which they seek treatment or testing. We suggest that both the exposed employee and source patient be sent to an Occupational Medicine Clinic familiar with post-exposure protocol.

1. Copy of OSHA's Occupational Exposure to Bloodborne Disease Pathogens Standard (available at OSHA.gov or your state specific OSHA website).
2. *Incident Information* (Form 1).
3. *Exposed Individual Consent or Declination* (Form 2).
4. *Healthcare Professional's Written Opinion* (Form 4).
5. *Source Individual Consent or Declination* (Form 3).
6. Copy all forms prior to a patient's or an employee's visit to a treating facility.

Incident Information Form for an Occupational

Bloodborne Pathogens Exposure – Form 1

To be completed by the exposed employee

Exposed Individual's Information

Report Date: _____

Name: _____

Address: _____

Telephone: _____ Social Security Number: _____

Date of Birth: _____ Preferred Language: _____

Exposure Information

Exposure Date: _____ Exposure Time: _____

Exact Location: _____

Potentially Infectious Material(s) involved: _____

❑ Blood ❑ Saliva ❑ Other

Route of Exposure

❑ Instrument Cut ❑ Splash ❑ Needle Stick ❑ Other

Describe your duties as they relate to the exposure incident (include procedure being performed):

_____

_____

_____

Describe the circumstances under which the exposure occurred:

_____

_____

_____

Which personal protective equipment was being used?

_____

_____

_____

I verify that the information above is correct and accurately describes the exposure incident in which I was involved.

Exposed Individual's Signature _____

Date: _____

1. Is the source individual known Yes No

2. Source individual's information completed on page 2? Yes No

Exposed Individual Consent or Declination for Blood Testing – Form 2

(Page 1 of 2)

Employee Name: _____ Today's Date: _____

Date of Incident: _____ Date of Birth: _____

On the above date, an exposure incident as defined by the Federal Bloodborne Pathogen Regulations occurred involving an employee performing his/her duties.

The regulation requires that a sample of blood be drawn as soon as possible form the source patient and the exposed employee to determine if any infectious diseases (HBV, HCV, and HIV) are present.

We are requesting to have your blood drawn and tested for HBV, HCV, and HIV. If you are a minor, consent to have your blood drawn and tested must be given by your parent or guardian. You are not legally required to have your blood drawn and tested. In the event that you decline to have your blood drawn and tested, however, we will not be able to determine whether you have been infected by either HBV, HBC, or HIV, nor can we advise you on appropriate steps to take as a result of such infection(s).

Please read the following and, if you consent, sign and date the form. Directions will be provided to the location for the test. You will be provided with the test results as soon as possible.

1. Authorize and consent to testing of a sample of my blood for the following:
   - Human Immunodeficiency Virus (HIV)
   - Hepatitis B Virus (HBV)
   - Hepatitis C Virus (HBC)
2. I understand the results of the test will be confidential and will not be disclosed.
3. I understand I can personally make arrangements to have my blood drawn, as authorized, or that arrangements will be made for me.
4. I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents. I have been given an opportunity to ask questions about the test and I believe that I have sufficient information to give informed consent/declination.

Exposed Individual Consent or Declination for Blood Testing – Form 2
Page 2 of 2

Section 1

Employee Name: _____

Employee Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Section 2

I REFUSE TO HAVE MY BLOOD DRAWN AND TESTED AT THIS TIME OR DRAWN AND STORED FOR UP TO 90 DAYS FOR POSSIBLE FUTURE TESTING, UPON MY WRITTEN CONSENT.

Employee Name: _____

Employee Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Source Individual Consent or Declination for Blood Testing - Form 3

Name of Source Individual: _____

Today's Date: _____

Date of Incident: _____

Date of Birth: _____

On the above date, an exposure incident as defined by the Federal Bloodborne Pathogen Regulations occurred involving an employee performing his/her duties.

The regulation requires that a sample of blood be drawn as soon as possible form the source patient and the exposed employee to determine if any infectious diseases (HBV, HBC, and HIV) are present.

We are requesting to have your blood drawn and tested. If you are a minor, consent to have your blood drawn and tested must be given by your parent or guardian. You are not legally required to have your blood drawn and tested. In the event that you decline to have your blood drawn and tested, however, we will not be able to determine whether you have been infected by either the Hepatitis B Virus (HBV), Hepatitis C (HBC), or the human immunodeficiency virus (HIV) nor can we counsel you on the appropriate steps to take as a result of such infections.

Please read the following and, if you consent, sign and date the form. Directions will be provided to the location for the test. You will be provided with the test results as soon as possible.

I authorize and consent to testing of a sample of my blood for the following: (check only one)

- ❑ Human Immunodeficiency Virus (HIV)
- ❑ Hepatitis B Virus (HBV)
- ❑ Hepatitis C Virus (HBC)

1. I understand the results of the test will be confidential and will not be disclosed.
2. I understand I can personally make arrangements to have my blood drawn or that arrangements will be made for me, with the assistance of district personnel or other designated parties.
3. I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents. I have been given an opportunity to ask questions about the test and I believe that I have sufficient information to give informed consent/declination.

Source Individual Consent or Declination for Blood Testing - Form 3

Section 1

Employee Name: _____

Employee Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Section 2

I REFUSE TO HAVE MY BLOOD DRAWN AND TESTED AT THIS TIME OR DRAWN AND STORED FOR UP TO 90 DAYS FOR POSSIBLE FUTURE TESTING, UPON MY WRITTEN CONSENT.

Employee Name: _____

Employee Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Healthcare Professional's Written Opinion - Form 4

Employee Name: _____

Date of Incident: _____

To the Healthcare Professional:

OSHA requires the healthcare professional who provides post-exposure evaluation and follow-up services to an employee to provide a written opinion in the form provided below. Please complete this form and return it to the employee at the time services are rendered. Thank you for your cooperation.

The employee named above has been informed of the results of the post-exposure health evaluation.

The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

Hepatitis B vaccination is ☐ is not ☐ indicated.

I hereby certify that on the date below, I evaluated the employee whose name appears above and informed the employee of the results of the evaluation; and any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

NOTE: ALL OTHER FINDINGS OR DIAGNOSIS ARE CONFIDENTIAL AND SHOULD NOT BE INCLUDED IN THIS WRITTEN REPORT.

Healthcare Professional Signature: _____

Date of Evaluation: _____

Note: This record will be maintained for the duration of employment plus 30 years. A copy of the Healthcare Professional's Written Opinion will be provided to the employee within 15 days after the evaluation is completed by the Healthcare Professional.