

BLOOD BORNE PATHOGEN EXPOSURE GUIDELINES

EXPOSURE INFORMATION

DATE/TIME OF EXPOSURE	TYPE OF EXPOSURE (<i>i.e.</i> , Needle stick, Instrument, Blood/Body Fluid Splash)			
NAME OF SOURCE (<i>If known</i>)	SOURCE CONTACT TELEPHONE NUMBERS			LAST 4 DIGITS OF SSN OF SOURCE (<i>If known</i>)
	HOME	WORK	CELL	

PATIENT INFORMATION

NAME	SS#:	DOB	AGE	SEX MALE FEMALE
PATIENT CONTACT TELEPHONE NUMBERS				
HOME	WORK	CELL		
DEPARTMENT	SUPERVISOR'S NAME/TELEPHONE NUMBER			
ALLERGIES	MEDICATIONS			

	INITIAL VISIT	1 WEEK POST EXPOSURE	6 WEEKS POST EXPOSURE	3 MONTHS POST EXPOSURE
DATE/PLACE:				
"EXPOSURE" HISTORY & IMMUNE STATUS <i>Refer all significant findings to a provider and explain here or on SF600.</i>	VITAL SIGNS: B/P: P: HT: WT: T: PAIN ASSESSMENT (Scale 0-10): PT. HISTORY Heart condition YES NO TYPE: Liver Disease YES NO TYPE: Immune problems YES NO TYPE: Possibly pregnant YES NO LMP: Completed Hepatitis B vaccine series? YES NO Date of last dose: # of doses received: Previous HBsAB titer done? YES NO Date: Results POS NEG Titer: Previous HIV done? YES NO Date: Results POS NEG Last Tetanus immunization/date: Source HIV Pos: YES NO Was PT. already seen by Infectious Disease? YES NO	Any complications since initial exposure? YES NO Explain:	SYMPTOMS HISTORY: Swollen Glands YES NO Sore Throat YES NO Fever>100°F YES NO Unusual fatigue YES NO Pain in muscles or joints YES NO Rash YES NO Night sweats YES NO Unexpected weight loss YES NO N/V/D YES NO Headaches YES NO Change in taste or smell YES NO Jaundice YES NO Abdominal pain YES NO Change in color of urine/feces YES NO	SYMPTOMS HISTORY: Swollen Glands YES NO Sore Throat YES NO Fever>100°F YES NO Unusual fatigue YES NO Pain in muscles or joints YES NO Rash YES NO Night sweats YES NO Unexpected weight loss YES NO N/V/D YES NO Headaches YES NO Change in taste or smell YES NO Jaundice YES NO Abdominal pain YES NO Change in color of urine/feces YES NO

	INITIAL VISIT	1 WEEK POST EXPOSURE	6 WEEKS POST EXPOSURE	3 MONTHS POST EXPOSURE
DATE/PLACE:				
"SOURCE" DATA	KNOWN SOURCE YES NO Was source information obtained YES NO Review Lab results-If POS, Notify Infect. Disease HIV-Date: POS NEG HBsAG-Date: POS NEG HCVAB-Date: POS NEG	Review any outstanding lab results	None	None
TEST (EXPOSED PT)	HIV (<i>with informed consent if not active duty</i>) HBsAG HBsAB HCVAB ALT	Review lab results All "source" data negative, no further follow-up required.	HIV HCVRNA (<i>if "source" was HCV +</i>) Other	HIV HCVAB ALT
ASSESSMENT	Potential exposure to blood borne pathogen	Review lab results Evidence of Hepatitis? Yes No Evidence of HIV? Yes No <i>If yes, consult required</i>	Review lab results Evidence of Hepatitis? Yes No Evidence of HIV? Yes No <i>If yes, consult required</i>	Review lab results Evidence of Hepatitis? Yes No Evidence of HIV? Yes No <i>If yes, consult required</i>
IMMUNIZATIONS (See recommendation on back page)	HBIG (.06ml/kg body wt. IM/5ml max) Hepatitis B Vaccine (1ml IM deltoid) HBsAB titer one month after immunization TD (.5ml IM) Other	HBIG (.06ml/kg body wt. IM/5ml max) Hepatitis B Vaccine (1ml IM deltoid) HBsAB titer one month after immunization	None required	Hepatitis B Vaccine (1ml IM deltoid) HBsAB titer one month after immunization
CONSULTS		Infectious Disease Gastroenterology Other	Infectious Disease Gastroenterology Other	Infectious Disease Gastroenterology Other
PT. EDUCATION	Initial Teaching Plan (<i>back of guideline</i>)	Review teaching plan	Review teaching plan	Review teaching plan
PT. FOLLOW-UP	Set date for next visit:	Date of next visit:	Date of next visit:	Date of next visit:
REMARKS		No show/missed f/u Other (<i>see SF 600</i>)	No show/missed f/u Other (<i>see SF 600</i>)	No show/missed f/u Other (<i>see SF 600</i>)

	6 MONTHS POST EXPOSURE	1 YEAR POST EXPOSURE <i>(only if source is positive for HIV and HCV)</i>	ADDITIONAL HISTORY/REMARKS/COMMENTS			
DATE/PLACE:						
"EXPOSURE" HISTORY & IMMUNE STATUS <i>Refer all significant findings to a provider and explain here or on SF600.</i>	SYMPTOMS HISTORY: Swollen glands YES NO Sore Throat YES NO Fever>100°F YES NO Unusual fatigue YES NO Pain in muscles or joints YES NO Rash YES NO Night sweats YES NO Unexpected weight loss YES NO N/V/D YES NO Headaches YES NO Change in taste or smell YES NO Jaundice YES NO Abdominal pain YES NO Change in color of urine/feces YES NO	SYMPTOMS HISTORY: Swollen glands YES NO Sore Throat YES NO Fever>100°F YES NO Unusual fatigue YES NO Pain in muscles or joints YES NO Rash YES NO Night sweats YES NO Unexpected weight loss YES NO N/V/D YES NO Headaches YES NO Change in taste or smell YES NO Jaundice YES NO Abdominal pain YES NO Change in color of urine/feces YES NO		SIGNATURE		
"SOURCE" DATA	None	None		INITIALS		
TEST (EXPOSED PT)	HIV HCVAB Other	HIV HCVAB HBsAB <i>(Required post Hep B vaccine series)</i> Other				
ASSESSMENT	Review lab results Evidence of Hepatitis? Yes No Evidence of HIV? Yes No <i>If yes, consult required</i>	Review lab results Evidence of Hepatitis? Yes No Evidence of HIV? Yes No <i>If yes, consult required</i>		SIGNATURE		
IMMUNIZATIONS (See recommendation on back page)	Hepatitis B Vaccine <i>(1ml IM deltoid)</i> HBsAB titer one month after immunization	None		INITIALS		
CONSULTS	Infectious Disease Gastroenterology Other	Infectious Disease Gastroenterology Other				
PT. EDUCATION	Review teaching plan	Review teaching plan				
PT. FOLLOW-UP	Date of next visit:	Date of next visit:				
REMARKS	No show/missed f/u Other <i>(see SF 600)</i>	No show/missed f/u Other <i>(see SF 600)</i>		SIGNATURE		
				INITIALS		

TEACHING PLAN						
PATIENT INFORMATION (HANDOUTS REVIEWED & PROVIDED)	DATE & INITIALS	DATE & INITIALS	DATE & INITIALS	DATE & INITIALS	DATE & INITIALS	DATE & INITIALS
1. Patient Guide to Post Exposure Evaluation						
2. Information following Exposure						
3. Condom Use						
4. Discussed safer sex precautions						
5. Discussed signs and symptoms to report						
6. Discussed safety measures to prevent re-exposure						
7. Discussed side effects of immunizations						
8. Discussed date and time of follow-up appointments and the importance of follow-up appointments						
9. Provided Health Care Professional's Written Opinion; signed statement below						
10. Signed Confidentiality of Disclosure statement below						
CONFIDENTIALITY OF DISCLOSURE						
<p>As a result of your exposure to blood or body fluids, the possibility of exposure to Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and Human Immunodeficiency Virus (HIV) exists. Federal law requires that you be informed of the presence of these infections in the person who was the source of your exposure, if that information is available. State and Federal law also require that you maintain the confidentiality of that information. Therefore, you must avoid unauthorized disclosure of the name, identifying data, or infectious status of the individual whose blood or body fluids was the source of your exposure.</p> <p>I ACKNOWLEDGE UNDERSTANDING OF THE ABOVE STATEMENT AND RECEIPT OF THE SIGNED FORM</p>						
EXPOSED INDIVIDUAL'S SIGNATURE	DATE	HEALTHCARE PROVIDER'S SIGNATURE			DATE	
HEALTHCARE PROFESSIONAL'S WRITTEN OPINION						
<p>The employer shall provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation. The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following:</p> <ul style="list-style-type: none"> Written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination. The employee has been informed of the results of the evaluation. The employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials, which require further evaluation or treatment. <p>I ACKNOWLEDGE UNDERSTANDING OF THE ABOVE STATEMENT AND RECEIPT OF THE SIGNED FORM</p>						
EXPOSED INDIVIDUAL'S SIGNATURE	DATE	HEALTHCARE PROVIDER'S SIGNATURE			DATE	
RECOMMENDATIONS FOR HEPATITIS B PROPHYLAXIS						
EXPOSED PERSON	Source: HBsAG positive	Source: HBsAG negative	Source: Not tested or unknown			
UNVACCINATED	HBIG * x 1 and initiate HB vaccine	Initiate HB vaccine	Initiate HB vaccine			
PREVIOUSLY VACCINATED (KNOWN RESPONDER)	No treatment	No treatment	No treatment			
KNOWN NON-RESPONDER	HBIG x 2 or HBIG x 1 and initiate revaccination	No treatment	If known high-risk source, treat as if source were HBsAG positive			
RESPONSE UNKNOWN	Test exposed person for anti-HBs 1. If adequate **, no treatment. 2. If inadequate, HBIG x 1 and vaccine booster.	No treatment	Test exposed person for anti-HBs 1. If adequate **, no treatment. 2. If inadequate, HBIG x 1 and vaccine booster.			
<p>*HBIG dose 0.06mg/kg/IM* **Adequate anti-HBs is ≥ 10SRU by RIA or positive EIA**</p> <p>References: MMWR Morbidity and Mortality Report, US Department of HHS/CDC, June 29, 2001/Vol 50/ No. RR-11 Dept of Labor Regulations, Standards-29CFR, Bloodborne pathogens.-1910.1030</p>						