DATE ___/___/___

Blood Borne Pathogen Exposure / Follow-up

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

EMPLOYEE HEALTH SERVICES
158 RUTLEDGE AVENUE
P.O. BOX 250215
CHARLESTON • S.C. 29425

Ph (843) 792-2991
FAX (843) 792-1200

Employee Completes

patient name ____________ *social security number* ____________

home phone ____________ *work phone* ____________ *ext.* ______

employer ____________ *department* ____________

Date & time of exposure ___/___/___ ___:___ am pm Location: ____________

Type of exposure: ☐Needle stick ☐Laceration ☐Bite ☐Splash ☐Other ____________

Circumstances of Exposure: ____________

Identifiable Source:
Name: ____________ Med. Record # ____________
Pt. location ____________
Blood contamination screen drawn on patient?: ☐Yes ☐No
Attending MD Name: ____________
Known Communicable Disease?: ____________

Completed by Nurse at Initial Visit

Employee's Medical History and Treatment:

- Employee completed Hepatitis B Vaccine series? ☐ YES ☐ NO
- HIV consent and Pre-HIV counseling provider signature? ☐ YES ☐ NO
- Blood contamination screen drawn on employee? ☐ YES ☐ NO
- Post exposure protocol (PEP) initiated? ☐ YES ☐ NO
- Baseline (PEP) labs drawn? ☐ YES ☐ NO
- PEP counseling by provider completed? ☐ YES ☐ NO
- PEP consents or declinations signed? ☐ YES ☐ NO
- Employee instructed to call and make follow-up appt in 3 days? ☐ YES ☐ NO
- Copy of all medical records prepared for Employee Health ☐ YES ☐ NO
- Employee permission for post exposure follow-up via telephone ☐ YES ☐ NO

Nurse Signature (initial BBP visit): ____________ Date___/___/___

Completed by EHS Nurse

Source Blood Contamination Results

STAT HIV________ HIV________ HbsAG________ HCV________

Employee Blood Contamination Results

HIV________ AHbsAG________ Other labs________

Post Exposure Follow-up: (patient please initial)

_______ I have been informed of the results of the post exposure evaluation

_______ I have been informed of any medical conditions resulting from exposure to blood or other potentially infectious materials which require evaluation or treatment.

_______ I have been counseled about adherence to Universal Precaution procedures and maintaining confidentiality of the source's medical information.

Employee Signature: ____________ Date: ___/___/___

Nurse Signature: ____________ Date: ___/___/___

White: Employee Health Canary: Safety Pink: Employee

POST-EXPOSURE CHEMOPROPHYLAXIS IN OCCUPATIONALLY EXPOSED HEALTH CARE WORKERS

VOLUNTARY STATEMENT OF INTENT TO AVOID PREGNANCY: WOMEN

To the best of my knowledge, I am not currently pregnant. Furthermore, I agree to avoid pregnancy while I am taking Chemoprophylaxis during the next four weeks and for four weeks thereafter. Should I have sexual relations during this period, I will practice a form of birth control (e.g., abstinence, oral contraceptives, intrauterine device, diaphragm plus condoms) that is deemed reliable by my clinician. I may decline to sign this statement. My declining to sign this statement will have no effect upon future treatment by my physician except that I will not be treated with Chemoprophylaxis.

______________________________ Participant's Signature

______________________________ Date

______________________________ Name (Print)

VOLUNTARY STATEMENT OF INTENT TO AVOID PREGNANCY: MEN

Should I have sexual relations during this period, I will practice a form of birth control with my partner(s) (e.g., abstinence, oral contraceptives, intrauterine device, diaphragm plus condoms) that is deemed reliable by my clinician. I may decline to sign this statement. My declining to sign this statement will have no effect upon future treatment by my physician except that I will not be treated with Chemoprophylaxis.

______________________________ Participant's Signature

______________________________ Date

______________________________ Name (Print)

CONSENT FOR OR REFUSAL OF CHEMOPROPHYLAXIS TREATMENT

I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS RELEVANT TO POST-EXPOSURE PROPHYLAXIS TREATMENT WITH ZIDOVUDINE, LAMIVUDINE, AND INDINAVIR, PER THE CDC RECOMMENDATIONS.

FOR FURTHER QUESTIONS OR PROBLEMS, I MAY CONTACT EMPLOYEE HEALTH SERVICES AT 792-2991.

I WOULD LIKE TO TAKE THE POST-EXPOSURE PROPHYLAXIS AND AGREE TO ABIDE BY THE PROTOCOL.

Participant's Signature ____________________ Date ____________________

Name (Print) ____________________

I DO NOT WISH TO TAKE THE POST-EXPOSURE PROPHYLAXIS UNDER THIS PROTOCOL.

Participant's Signature ____________________ Date ____________________

Name (Print) ____________________

Signature of Supervising Clinician ____________________ Date ____________________