



# FAIR HAVEN VOL. FIRE COMPANY No. 1



## EXPOSURE INCIDENT REPORT (Routes and Circumstances of Exposure Incident) Please Print

Date Completed: \_\_\_\_\_

Employee's Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employee Vaccination Status: \_\_\_\_\_

Date of Exposure: \_\_\_\_\_ Time of Exposure: \_\_\_\_\_  am  pm

Location of Incident (Home, Street, Clinic, etc.) Be Specific: \_\_\_\_\_  
\_\_\_\_\_

Nature of Incident (Auto Accident, Trauma, Medical Emergency) Be Specific: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe what task(s) you were performing when the exposure occurred. Be Specific: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you wearing personal protective equipment (PPE)?  Yes  No

If Yes, list: \_\_\_\_\_

Did the PPE fail?  Yes  No

If Yes, explain how: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What body fluid(s) were you exposed to (blood or other potentially infectious material)? Be Specific: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## EXPOSURE INCIDENT REPORT (Continued)

What part(s) of your body became exposed? Be specific: \_\_\_\_\_

Estimate the size of the area of your body that was exposed: \_\_\_\_\_

For how long? \_\_\_\_\_

Did a foreign body penetrate your body (needle, nail, auto part, dental wires, etc.)?  Yes  No

If Yes, what was the object? \_\_\_\_\_

Where did it penetrate your body? \_\_\_\_\_

Was any fluid injected into your body?  Yes  No

If yes, what fluid? \_\_\_\_\_ How much? \_\_\_\_\_

Did you receive medical attention?  Yes  No

If yes, where? \_\_\_\_\_

When? \_\_\_\_\_

By Whom? \_\_\_\_\_

Identification of source individual(s) \_\_\_\_\_

Name(s) \_\_\_\_\_

Did you treat the patient directly?  Yes  No

If yes, what treatment did you provide? Be specific: \_\_\_\_\_

Identification of source individual(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# FAIR HAVEN VOL. FIRE COMPANY No. 1



## REQUEST FOR SOURCE INDIVIDUAL EVALUATION

Dear **(Emergency Room Medical Director, Infection Control Practitioner)**:

During a recent transport of a patient to your facility, one of our pre-hospital care providers was involved in an event which may have resulted in exposure to a Bloodborne Pathogen.

I am asking you to perform an evaluation of the source individual who was transported to your facility. Given the circumstances surrounding this event, please determine whether our pre-hospital care worker is at risk for infection and/or requires medical follow-up.

Attached is a "Documentation and Identification of Source Individual" form which was initiated by the exposed worker. Please complete the source individual section and communicate the findings to the designated medical provider.

The evaluation form has been developed to provide confidentially assurances for the patient and the exposed worker concerning the nature of the exposure. Any communication regarding the findings is to be handled at the medical provider level.

We understand that information relative to human immunodeficiency virus (HIV) and AIDS has specific protections under the law and cannot be disclosed or released without the written consent of the patient. It is further understood that disclosure obligates persons who receive such information to hold it confidential.

Thank you for your assistance in this very important matter.

Sincerely,  
Richard A. Brister, Jr.

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Fair Haven Vol. Fire Company No. 1  
Infection Control Officer

OCC-3  
NOV13



# FAIR HAVEN VOL. FIRE COMPANY No. 1



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## DOCUMENTATION AND IDENTIFICATION OF SOURCE INDIVIDUAL

Name of Exposed Employee: \_\_\_\_\_

Name of Medical Provider Who Should be Contacted: \_\_\_\_\_

Phone Number of Medical Provider: \_\_\_\_\_

### ***Incident Information***

Date: \_\_\_\_\_

Individual Who is the Source of the Exposure:

Name or Medical Record Number: \_\_\_\_\_

### ***Nature of the Incident***

- Contaminated Needle Stick Injury
- Blood or Body Fluid Splash onto Mucous Membrane or Non-Intact Skin
- Other: \_\_\_\_\_

### ***Report of Source Individual Evaluation***

Chart Review By: \_\_\_\_\_ Date: \_\_\_\_\_

Source Individual  
Unknown – Researched By: \_\_\_\_\_ Date: \_\_\_\_\_

Testing of Source Individual's Blood:                      **Consent:**                       Obtained                       Refused

#### **Check One:**

- Evaluation of the source individual reflected no known exposure to Bloodborne Pathogens.
- Evaluation of the source individual reflected known exposure to Bloodborne Pathogens.
- Evaluation of the source individual reflected possible exposure to Bloodborne Pathogens and medical follow-up is recommended.
- Identification of source individual infeasible or prohibited by state or local law.

Name or Person  
Completing Report: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** Report the results of the source individual's blood test to the medical provider named above who will inform the exposed employee. Do not report blood test findings to the employer.

**HIV-related information cannot be released without written consent of the source individual.**



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## EMPLOYEE EXPOSURE FOLLOW-UP RECORD

Employee's Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Occurrence Date: \_\_\_\_\_ Reported Date: \_\_\_\_\_

Occurrence Time: \_\_\_\_\_  am  pm

### SOURCE INDIVIDUAL FOLLOW-UP

Request Made to: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_  am  pm

### EMPLOYEE FOLLOW-UP

Employee's Health  
File Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Information Given on Source Individual's Blood Test Results:  Yes  Not Obtained

### *Referred to Healthcare Professional with Required Information*

Name of Healthcare Professional: \_\_\_\_\_

By Whom: \_\_\_\_\_ Date: \_\_\_\_\_

### *Blood Sampling/Testing Offered*

By Whom: \_\_\_\_\_ Date: \_\_\_\_\_

### *Vaccination Offered/Recommended*

By Whom: \_\_\_\_\_ Date: \_\_\_\_\_

### *Counseling Offered*

By Whom: \_\_\_\_\_ Date: \_\_\_\_\_

### *Employee Advised of Need for Further Evaluation of Medical Condition*

By Whom: \_\_\_\_\_ Date: \_\_\_\_\_