

**SAINT FRANCIS UNIVERSITY
STUDENT HEALTH SERVICES
BLOOD BORNE PATHOGEN EXPOSURE FORM**

General Information:

Student Name: _____ Date of Birth: _____
Student Phone: _____ Program: PA PT OT Nursing
Date and Time of Exposure: _____
Type of Exposure: Needlestick ___ Sharp Object ___ Mucous Membrane ___ Other _____
Body Part Exposed: _____
Duration of Contact/Volume of Exposure: _____
Wound Care: _____

Device and/or body fluid involved: _____

What Caused Exposure: _____

Barriers Used: _____

Source Information:

Is source: Known ___ Unknown ___
Were labs or are labs being drawn on source: Yes ___ No ___
List results of source labs if available: HIV ___ Hep BsAg ___ HCV ___ Other _____
Check if no source information available at all: _____

Student Information:

Is Hep B series complete: Yes ___ No ___ Hep B titer results: _____
If series not complete or titer neg, was HBIG given: Yes ___ No ___
Is Tetanus up to date: Yes ___ No ___ If no, was Tetanus given: Yes ___ No ___
Has student contacted occupational health at rotation site: Yes ___ No ___
Is occupational health evaluating and recommending follow up: Yes ___ No ___
Has student had post exposure testing done through site: Yes ___ No ___
Was Post Exposure Prophylaxis started: Yes ___ No ___
If yes, explain details: _____

*If occupational health at rotation site is evaluating and making recommendations, the Student Health Center will not make further recommendations. It is up to the student to be aware of recommendations and follow through. SHC can give lab orders if needed at later dates. If occupational health is not following student follow with the recommended lab studies. Remind student that he/she is responsible for any cost incurred, not Saint Francis University.

Source patient labs are negative, no further testing needed: _____
If source patient labs are positive, follow CDC guidelines for specific recommendations, if not being done through rotation site.

If source unavailable recommend following labs:

Baseline: HIV ___, anti-HCV ___, Hep BsAg ___ (if hep B series not complete or Titer neg)
6 Weeks: HIV ___, anti-HCV ___, Hep BsAg ___
3 Months: HIV ___, anti-HCV ___, Hep BsAg ___
6 Months: HIV ___, anti-HCV ___, Hep BsAg ___
12 Months: HIV ___, anti-HCV ___, Hep BsAg ___