

## Blood Borne Pathogen Exposure Response Form

**Call received by (Public Health Employee):**

Name \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ Phone number \_\_\_\_\_

**Caller/Outside entity requesting assistance:**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Title \_\_\_\_\_

Department/Entity \_\_\_\_\_

Phone number \_\_\_\_\_ Alternative phone number \_\_\_\_\_

Email contact name: \_\_\_\_\_ Email address: \_\_\_\_\_

**Source person/patient (SP):**Last name \_\_\_\_\_ First name \_\_\_\_\_ DOB \_\_\_\_\_  Anonymous

Last Known Home Address \_\_\_\_\_

Phone number \_\_\_\_\_

MRN \_\_\_\_\_ Hospital \_\_\_\_\_

Add'l MRN \_\_\_\_\_ Add'l Hospital \_\_\_\_\_

Alternate contact: \_\_\_\_\_

**Current SP location (hospital, jail, home, coroner's office, other, unknown):** \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

Floor/pod \_\_\_\_\_ Room \_\_\_\_\_

Medical provider/coroner/custody health contact name \_\_\_\_\_

Medical provider/coroner/custody health contact phone \_\_\_\_\_

Other information (homeless, left AMA, unable to locate): \_\_\_\_\_

Emergency contact information: \_\_\_\_\_

**SP disposition (check all that apply):** Alive  Arrested (if yes, Case #: \_\_\_\_\_)  Deceased (if yes, Coroner's case #: \_\_\_\_\_) Incarcerated  Unconscious  Received court order for testing  Unable to consent to testing Other (if other, please specify: \_\_\_\_\_)**SP risk factors (check all that apply):** Drug use  Exchange sex  Known HIV  Known HBV  Known HCV Other (if other, please specify \_\_\_\_\_)**SP testing performed:**  Yes  No Facility where test performed \_\_\_\_\_

Tests performed &amp; Test results (check all that apply):

 HIV Rapid Test Result \_\_\_\_\_  HIV 4<sup>th</sup> generation screening test Result \_\_\_\_\_  HIV RNA or viral load Result \_\_\_\_\_ HBsAg Result \_\_\_\_\_  HBsAb Result \_\_\_\_\_  HBcAb Result \_\_\_\_\_  HepB DNA Result \_\_\_\_\_ HepCAb Result \_\_\_\_\_  HepB RNA Result \_\_\_\_\_Were results shared with Exposed Person or their provider?  Yes  No  UnkDid SP provide consent for testing?  Yes  No  UnkDid SP provide consent for sharing results with EP, EP's provider, and PHD?  Yes  No  UnkWas consent to share results documented?  Yes  No  Unk

**Exposed Person/Patient (EP) (complete one sheet per each exposed person):**

**EP#1**

Last name \_\_\_\_\_ First name \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_  
Phone number \_\_\_\_\_ Alternative phone number \_\_\_\_\_  
Employer \_\_\_\_\_  
Healthcare facility or emergency dept where seen after exposure \_\_\_\_\_  
Secondary health care facility or occupational health provider \_\_\_\_\_  
Insurance status:  Private  MediCal  Worker's comp  Other (if other, please specify: \_\_\_\_\_)

**Circumstances of exposure:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_  
Description of exposure: \_\_\_\_\_

SP body fluid (check all that apply):  Blood  Saliva  Urine  Vomit  Feces  Semen/pre-ejaculate  Vaginal fluid  
 Rectal fluid  Breast milk  Peritoneal fluid  Spinal fluid  Unknown If not blood, was there visible blood in fluid?: \_\_\_\_\_

EP contact site:  Open sore  Membrane exposure  Penetrating wound  Needlestick  
 Other (if other, please specify \_\_\_\_\_)

EP wearing personal protective equipment?  Yes  No  Unk  
If yes:  Gloves  Eye protection  Face mask  Gown  Other (if other, please specify: \_\_\_\_\_)

For occupational exposure:  
Is infection prevention/occupational health department aware of incident?  Yes  No  Unk

**Healthcare facility for EP initial care:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Hospital or Clinic \_\_\_\_\_ MRN \_\_\_\_\_  
Provider name \_\_\_\_\_ Provider contact (phone/pager) \_\_\_\_\_

EP tests performed & test results:  
 HIV Rapid Test Result \_\_\_\_\_  HIV 4<sup>th</sup> generation screening test Result \_\_\_\_\_  HIV RNA or viral load Result \_\_\_\_\_  
 HBsAg Result \_\_\_\_\_  HBsAb Result \_\_\_\_\_  HBcAb Result \_\_\_\_\_  HepB DNA Result \_\_\_\_\_  
 HepCAb Result \_\_\_\_\_  HepB RNA Result \_\_\_\_\_

Were results shared with EP and/or provider:  Yes  No  Unk  
HIV PEP prescribed:  Yes  No  Unk

What PEP meds were prescribed:  Isentress(Raltegravir)  Tivicay(Dolutegravir)  Truvdad(Tenofovir disoproxil fumarate/Emtricitabine)  
 Stribild(Elvitegravir/cobicistat/Tenofovir disoproxil fumarate/Emtricitabine)  Biktarvy(Biktegravir/Tenofovir Alafenamide/Emtricitabine)  
 Other: (if other, please specify: \_\_\_\_\_)

First dose HIV PEP given in ED:  Yes  No  Unk  
PEP Rx given:  Yes  No  Unk PEP Rx filled:  Yes  No  Unk  
HBV status:  Vaccinated  Prior infection or HBsAb pos  Chronic infection  Non-immune  Unknown  
HBIG given:  Yes  No  Unk  
Referred to occupational health:  Yes  No  Unk Seen by occupational health:  Yes  No  Unk

Notes: \_\_\_\_\_

**EP#2**

Last name \_\_\_\_\_ First name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_ Alternative phone number \_\_\_\_\_

Employer \_\_\_\_\_

Healthcare facility or emergency dept where seen after exposure \_\_\_\_\_

Secondary health care facility or occupational health provider \_\_\_\_\_

Insurance status:  Private  MediCal  Worker's comp  Other (if other, please specify: \_\_\_\_\_)

**Circumstances of exposure:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Description of exposure: \_\_\_\_\_

SP body fluid (check all that apply):  Blood  Saliva  Urine  Vomit  Feces  Semen/pre-ejaculate  Vaginal fluid  
 Rectal fluid  Breast milk  Peritoneal fluid  Spinal fluid  Unknown If not blood, was there visible blood in fluid?: \_\_\_\_\_

EP contact site:  Open sore  Membrane exposure  Penetrating wound  Needlestick  
 Other (if other, please specify \_\_\_\_\_)

EP wearing personal protective equipment?  Yes  No  Unk

If yes:  Gloves  Eye protection  Face mask  Gown  Other (if other, please specify: \_\_\_\_\_)

**For occupational exposure:**

Is infection prevention/occupational health department aware of incident?  Yes  No  Unk

**Healthcare facility for EP initial care:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Hospital or Clinic \_\_\_\_\_ MRN \_\_\_\_\_

Provider name \_\_\_\_\_ Provider contact (phone/pager) \_\_\_\_\_

**EP tests performed & test results:**

HIV Rapid Test Result \_\_\_\_\_  HIV 4<sup>th</sup> generation screening test Result \_\_\_\_\_  HIV RNA or viral load Result \_\_\_\_\_

HBsAg Result \_\_\_\_\_  HBsAb Result \_\_\_\_\_  HBcAb Result \_\_\_\_\_  HepB DNA Result \_\_\_\_\_

HepCAb Result \_\_\_\_\_  HepB RNA Result \_\_\_\_\_

Were results shared with EP and/or provider:  Yes  No  Unk

HIV PEP prescribed:  Yes  No  Unk

What PEP meds were prescribed:  Isentress(Raltegravir)  Tivicay(Dolutegravir)  Truvada(Tenofovir disoproxil fumarate/Emtricitabine)

Stribild(Elvitegravir/cobicistat/Tenofovir disoproxil fumarate/Emtricitabine)  Biktarvy(Biktegravir/Tenofovir Alafenamide/Emtricitabine)

Other: (if other, please specify: \_\_\_\_\_)

First dose HIV PEP given in ED:  Yes  No  Unk

PEP Rx given:  Yes  No  Unk PEP Rx filled:  Yes  No  Unk

HBV status:  Vaccinated  Prior infection or HBsAb pos  Chronic infection  Non-immune  Unknown

HBIG given:  Yes  No  Unk

Referred to occupational health:  Yes  No  Unk Seen by occupational health:  Yes  No  Unk

Notes: \_\_\_\_\_

### EP#3

Last name \_\_\_\_\_ First name \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_  
Phone number \_\_\_\_\_ Alternative phone number \_\_\_\_\_  
Employer \_\_\_\_\_  
Healthcare facility or emergency dept where seen after exposure \_\_\_\_\_  
Secondary health care facility or occupational health provider \_\_\_\_\_  
Insurance status:  Private  MediCal  Worker's comp  Other (if other, please specify: \_\_\_\_\_)

#### Circumstances of exposure:

Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_  
Description of exposure: \_\_\_\_\_

SP body fluid (check all that apply):  Blood  Saliva  Urine  Vomit  Feces  Semen/pre-ejaculate  Vaginal fluid  
 Rectal fluid  Breast milk  Peritoneal fluid  Spinal fluid  Unknown If not blood, was there visible blood in fluid?: \_\_\_\_\_

EP contact site:  Open sore  Membrane exposure  Penetrating wound  Needlestick  
 Other (if other, please specify \_\_\_\_\_)  
EP wearing personal protective equipment?  Yes  No  Unk  
If yes:  Gloves  Eye protection  Face mask  Gown  Other (if other, please specify: \_\_\_\_\_)

For occupational exposure:  
Is infection prevention/occupational health department aware of incident?  Yes  No  Unk

#### Healthcare facility for EP initial care:

Date \_\_\_\_\_ Time \_\_\_\_\_ Hospital or Clinic \_\_\_\_\_ MRN \_\_\_\_\_  
Provider name \_\_\_\_\_ Provider contact (phone/pager) \_\_\_\_\_

EP tests performed & test results:  
 HIV Rapid Test Result \_\_\_\_\_  HIV 4<sup>th</sup> generation screening test Result \_\_\_\_\_  HIV RNA or viral load Result \_\_\_\_\_  
 HBsAg Result \_\_\_\_\_  HBsAb Result \_\_\_\_\_  HBcAb Result \_\_\_\_\_  HepB DNA Result \_\_\_\_\_  
 HepCAb Result \_\_\_\_\_  HepB RNA Result \_\_\_\_\_

Were results shared with EP and/or provider:  Yes  No  Unk  
HIV PEP prescribed:  Yes  No  Unk  
What PEP meds were prescribed:  Isentress(Raltegravir)  Tivicay(Dolutegravir)  Truvada(Tenofovir disoproxil fumarate/Emtricitabine)  
 Stribild(Elvitegravir/cobicistat/Tenofovir disoproxil fumarate/Emtricitabine)  Biktarvy(Biktegravir/Tenofovir Alafenamide/Emtricitabine)  
 Other: (if other, please specify: \_\_\_\_\_)

First dose HIV PEP given in ED:  Yes  No  Unk  
PEP Rx given:  Yes  No  Unk PEP Rx filled:  Yes  No  Unk  
HBV status:  Vaccinated  Prior infection or HBsAb pos  Chronic infection  Non-immune  Unknown  
HBV Ig given:  Yes  No  Unk  
Referred to occupational health:  Yes  No  Unk Seen by occupational health:  Yes  No  Unk

Notes: \_\_\_\_\_