Incident Number: _____

Bloodborne Pathogen Exposure Form

Immediate Supervisor should complete this form promptly with employee input. Please print clearly and forward to the Risk Manager along with the IAF, supplemental medical form, and 801.

Involved Employee: _____ Immediate Supervisor: _____

Incident Date/Time: _____ Location:_____ SPD Case # _____

Was an Incident Analysis Form (IAF) Completed? ☐ Yes ☐ No, but will soon.
Was a Supplemental Medical Form Completed? ☐ Yes ☐ N/A (near miss)
Was an 801 form completed? ☐ Yes ☐ N/A (no medical treatment given)

1. Was the employee exposed to
   a. ☐ Blood
   b. ☐ Other Potential Infectious Materials (OPIM). Describe: _____
2. Describe the exposure in detail (route of exposure, circumstances).
3. List the sites from which the source was bleeding, or source of OPIM.
4. Exactly where was your body, face, equipment or clothing contaminated with the source's blood or OPIM?
5. How much of the source's blood or OPIM was present?
   Examples might be: small flecks or spots of blood on the back of my right hand and blood smeared on most of my right forearm; my right and left arms were covered with source's blood. ***We are required to report the amount of blood present. If you were contaminated with a large quantity of blood, then we are required to refer for medical evaluation****.*
6. Describe type of controls in place at time of incident including engineering controls and personal protective equipment worn if any, at the time of the incident:
   ☐ Latex gloves ☐ Leather gloves ☐ Glasses ☐ Goggles ☐ Mask ☐ Face shield
   ☐ Long sleeve shirt ☐ Short sleeve shirt
   ☐ Other. Describe: _____
7. How long was the blood or OPIM present before you were able to remove it? What did you cleanse with? What first aid was applied?
8. Was <u>your</u> skin intact at the time of the incident? ☐ Yes ☐ No
   a. Please describe the type and location of your wounds (*Examples: hands were chafed, scratched, cut or scraped)*

b. Did you have hangnails? ☐ Yes ☐ No
c. How old were your wounds? _____
d. Were any of your wounds contaminated? _____
e. If so, which ones? _____

9. Did your eye(s) get contaminated with saliva or blood? ☐ Yes ☐ No
   a. Were you wearing glasses? ☐ Yes ☐ No
   b. Were you able to wash out your eyes? ☐ Yes ☐ No
   c. Was blood present in the source's saliva or were his/her gums or mouth bleeding or in poor condition? ☐ Yes ☐ No
   d. How did the eye contamination occur?

10. Did your mouth get contaminated with saliva or blood? ☐ Yes ☐ No
   a. Did you have cuts or open wounds in your mouth? ☐ Yes ☐ No
   b. Was blood present in the source's saliva or were his/her gums or mouth bleeding or in poor condition? ☐ Yes ☐ No

11. Is the source individual known? ☐ Yes ☐ No If so, please provide name/address so that consent for blood testing can be obtained.

   a. Name: _____ DOB: _____
   b. Address: _____

12. Where is the source now? ☐ LCJ ☐ Springfield Municipal Jail ☐ CLC'd ☐ Unknown

13. Did the source consent to blood draw and testing? ☐ Yes ☐ No

14. Was a court order obtained for female in first/second trimester pregnancy? ☐ Yes ☐ No

A blood draw needs to be done from the source person and notification must be made to Cascade Health Solutions to schedule an apt for employee blood draw and follow-up testing. Phone 541-228-3100

For source testing, contact MedExpress at 541-228-3111 – this is a 24 hour dispatch line. If suspect is not cooperative a court order will need to be obtained. (LCJ Medical staff will NOT provide any assistance in obtaining the blood draw.) If custody is cooperative, hospital staff may be able to assist in source blood draw, assuming suspect hasn't already been lodged at LCJ – in that case, MedExpress needs to handle the blood draw.

Was MedExpress contacted and arrangements made for source testing? ☐ Yes ☐ No

If no, please explain the reason no follow-up testing is requested. Examples: skin intact, no actual exposure to open skin; exposure minimal.

15. Do you have any additional information which may be important for your record and this exposure?

16. Referral to medical evaluator? ☐ Yes ☐ No Date: _____
If not explain: _____

NOTE: THE OREGON HEALTH DIVISION "SOURCE CONSENT" FORM WILL BE SENT BY THE EMPLOYEE'S TREATING PHYSICIAN TO THE SOURCE OR HIS/HER MEDICAL PROVIDER TO ATTEMPT TO OBTAIN PERMISSION FOR SOURCE HIV/HBV BLOOD TESTING. THE MEDICAL EVALUATOR HAS BEEN INFORMED AS TO OUR POLICY AND THE OSHA RULES. **ALL MEDICAL DATA IS CONFIDENTIAL**.

Investigator Name: _____ Signature: _____ Date: _____

HR/Risk Use:
Date HR/Risk Notified: _____ Incident Number: _____