Post-Exposure Incident

Medical Form and Incident Report

Employee Information

Name of Potentially Exposed Employee:

_____
Last First M.I.

Social Security Number:_____

Home Phone Number:_____

Date of Birth:_____

Home Address:_____
Number and Street

_____
City, State, ZIP County

Department:_____

Campus Phone Number:_____

Job Title/Position:_____

Immediate Supervisor:_____

Incident Details

Exposure occurred on: ❑ OXF ❑ MUH ❑ MUM campus

Building:_____ Room Number:_____

Other Location:_____

Date of Exposure Time of Exposure

_____ _____❑ AM ❑ PM
Month Day Year

Part(s) of Body Exposed: (e.g. left thumb, right eye)

_____

Type of Exposure:
❑ Direct Mucous Membrane Contact/Splash
❑ Inhalation
❑ Indigestion
❑ Parenteral (Sharps)
❑ Non-intact Skin Contact
❑ Other: _____

Contaminant: ❑ Blood ❑ Other:_____

Was anyone else exposed? ❑ Yes ❑ No ❑ Unknown

[If YES, see page 2]

Today's Date: _____

Vaccination Status

Tetanus: Date of last injection_____

Hepatitis B Vaccine

❑ Has not received the Hepatitis B Vaccine

❑ Completed the 3 dose series [month\year] _____

❑ Currently enrolled in a vaccination program [dose & dates]

First _____ Second _____ Third _____

❑ Booster [month\year] _____

Incident Evaluation

Was employee performing his/her regular duties at the time of exposure? ❑ Yes ❑ No ❑ Unknown

Was PPE used? ❑ Yes ❑ No ❑ Unknown, If YES, define:

_____

Did PPE fail? ❑ Yes ❑ No ❑ Unknown, If YES, how:

_____

Describe decontamination of person exposed:_____

_____

Specify decontamination/clean-up of incident scene and disposal of contaminated materials, if applicable: _____

_____

Incident Description

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

❑ continued on additional sheet

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Witnesses

If possible, provide names, addresses, and phone numbers of any other person(s) who may have witnessed the incident:

❑ Potentially Exposed ❑ Miami University Employee

Name:_____

Address or Dept:_____

_____

Phone:_____

❑ Potentially Exposed ❑ Miami University Employee

Name:_____

Address or Dept:_____

_____

Phone:_____

Required Signatures

❑ Employee **consented** to post-exposure evaluation and follow-up [continue with Medical Evaluation and Packet Instructions.]

❑ Employee **refused** post-exposure evaluation and follow-up [attach signed consent/declination FORM B and refer to Packet Instructions for remittance.]

_____

Employee signature and date

_____

Signature of person completing report and date (if applicable)

Additional Notes

_____

_____

_____

_____

_____

_____

_____

_____

❑ continued on additional sheet

Medical Evaluation

TO BE COMPLETED BY EVALUATING PHYSICIAN

Did Employee incur an exposure incident? ❑ Yes ❑ No

Testing of Exposed Employee

Antibody to HepBsAg ..... ❑ Yes ❑ No
Antibody to HepC ..... ❑ Yes ❑ No
HIV ..... ❑ Yes ❑ No

Testing of Source

HepBsAg..... ❑ N/A ❑ Yes ❑ No
HepC..... ❑ N/A ❑ Yes ❑ No
HIV..... ❑ N/A ❑ Yes ❑ No

Did you or your staff administer:

HepB Booster..... ❑ Yes ❑ No
HBIG..... ❑ Yes ❑ No

Did the exposed employee receive:

Advice regarding HepB immunization ..... ❑ Yes ❑ No
Bloodborne disease counseling..... ❑ Yes ❑ No
Follow-up instructions ..... ❑ Yes ❑ No

Additional treatment:_____

_____

_____

_____

_____

Please complete Physician's Written Opinion

Evaluating Physician:_____

Evaluating Nurse:_____

Date of Evaluation:_____

Source Individual

Name of Exposure Source: ❑ Source Unknown

_____

Last First M.I.

Social Security Number:_____

Home Phone Number:_____

Address or Dept:_____

_____