

Please complete all information on the other side of this report form before completing this side and complete this side only if incident involving an exposure to blood or other potentially infectious material has occurred.

City of Winona Communicable Disease Exposure Report Form

Exposed Employees Name: _____

Date/Time of Exposure: _____ Last Bloodborne Pathogens Training: _____

Name of Person who you were exposed to (source): _____
(if known)

Location of exposure: _____ Address of source: _____
(or field incident number) (if Known)

Medical facility transferred to: _____

Type of Incident: Medical M.V. Accident Trauma Criminal investigation/arrest
 Maintenance Other _____

How did exposure occur? _____

What were you exposed to? Blood saliva Feces urine Vomit Other _____

What part(s) of your body was exposed to contaminate? Be specific _____
Was skin intact?(rashes, cuts, etc.) _____

What protective equipment was being used? _____

(List brand name of equipment if known)

How could exposure have been prevented? _____

Medical attention provided by: _____

Source Hepatitis B, C or HIV status known? yes no

Testing of source patient's blood has been requested completed

Has exposed employee been vaccinated for Hepatitis B? yes no

Does this exposure require follow-up testing or treatment? yes no

Draw blood on exposed for testing:

- a) Hepatitis B profile if not vaccinated c) Hepatitis C
 b) Anti HBs titer if vaccinated d) HIV

Health Care Providers Signature: _____ Date: _____

I, the exposed, give permission for my blood to be drawn and be tested for the above checked item/s

now or held up to 90 days for future testing. I authorize release of my test results for follow-up by the Occupational Health and Safety Coordinator or Dr. _____

Signature: _____ Date: _____

I understand that blood tests are confidential and will not release any information obtained during this exposure follow-up on the source patient without their consent

Signature: _____ Date: _____