Bloodborne Pathogen Exposure Source Risk Assessment, MMC Healthcare Worker Exposure

Exposure Date & Time: _____ Name of Exposed Healthcare Worker _____
Initials and location of Source patient _____

EXPOSURE TO HEPATITIS B ONLY (HCW exposed only to non-bloody saliva)? ❒ No ❒ Yes
If yes, do patient interview and medical record review for Hepatitis B risk only (no HIV consent)

MEDICAL RECORD REVIEW *(to be done in addition to patient interview)*
Elevated liver lab tests (ALT, AST, LDH, ALk Phos, Bilirubin) ❒ No ❒ Yes _____
Known risk factors ❒ No ❒ Yes _____
Documented History of: ❒ Hepatitis B - Treatment _____ ❒ Hepatitis C – Treatment _____
(check if yes) ❒ HIV or AIDS - Current drug regimen _____
Last viral load_____ Last CD4 _____ Treating provider _____
Known drug resistance to _____

PATIENT INTERVIEW
Interview was: ❒ In person with source patient
❒ Interview not done with patient – reason _____
❒ With _____(relation to patient _____) ❒ In person ❒ by phone
❒ No interview done (patient or family unable/unavailable to interview)

"Certain behaviors increase the risk for HIV or Hepatitis. Do you have any of the following risk factors, now or in the past?"

Unprotected sex with multiple or anonymous partners	❒ No	❒ Yes	❒ Within last 6 weeks	❒ Unknown
Male having unprotected sex with another male	❒ No	❒ Yes	❒ Within last 6 weeks	❒ Unknown
Sex partner who had multiple sex partners	❒ No	❒ Yes	❒ Within last 6 weeks	❒ Unknown
Injected IV drugs or sex partner who injected IV drugs	❒ No	❒ Yes	❒ Within last 6 weeks	❒ Unknown
Shared IV needles with others	❒ No	❒ Yes	❒ Within last 6 weeks	❒ Unknown
Been a victim of oral, anal or vaginal rape	❒ No	❒ Yes	❒ Within last 6 weeks	❒ Unknown
Tattoos or body piercing – in what setting?_____	❒ No	❒ Yes	❒ Unknown	
History of any sexually-transmitted disease	❒ No	❒ Yes	❒ Unknown	
Have you ever had your blood tested for HIV?	❒ No	❒ Yes	if yes, was it positive?	❒Yes ❒ No
Did you receive any blood transfusions prior to 1987?	❒ No	❒ Yes	if yes, when?_____	❒ Unknown
Have you ever donated blood, semen or organs?	❒ No	❒ Yes	if yes, when?_____	❒ Unknown
Have you ever been exposed to someone else's blood or body fluids?	❒ No	❒ Yes	❒ Unknown	

If yes, when?_____ Did you receive any treatment? _____
Did you immigrate to the US? ❒ No ❒ Yes If yes, when and from where? _____
Have you had, or do you currently have any of the following illnesses?

❒ No ❒ Yes	Kidney disease requiring dialysis	Still on dialysis?	❒ No ❒ Yes
❒ No ❒ Yes	Hemophilia (Factor VIII or IX)		
❒ No ❒ Yes	Hepatitis B	Treatment, if any	_____
❒ No ❒ Yes	Hepatitis C	Treatment, if any	_____
❒ No ❒ Yes	HIV or AIDS	Treatment, if any	_____

CONSENT STATUS:
❒ HIV Consent given by, in descending order, any of the following who is reasonably available:
❒ 1. Source patient ❒ 2. Patient's legal guardian ❒ 3. Patient's Healthcare Power of Attorney
❒ 4. Adult relative ❒ 5. Adult with whom the patient has a meaningful social and emotional relationship
❒ 6. Consent given by Hospital Epidemiologist or designee per protocol order

❒ Patient declined HIV testing; HIV testing will not be performed – agrees to Hepatitis testing? ❒ No ❒ Yes

❒ Hepatitis testing (all source patients): Patient/designated representative is aware, and agrees with plan to have blood drawn for Hepatitis B and C

Signature of provider obtaining data _____Date _____

WHEN COMPLETE, IMMEDIATELY FAX BOTH PAGES TO: EMPLOYEE HEALTH @662-6392
If HCW being seen in ED or BFC, fax THIS PAGE ONLY to MMC ED @ 662-6886; or BRIGHTON FIRSTCARE @ 662-8133
(Originals- page 1 & 2- to EHS via interoffice/leave in AIM PA office)

Bloodborne Pathogen Exposure Source Risk Assessment, MMC Healthcare Worker Exposure

Initials of Exposed Healthcare Worker _____

Exposure Date & Time: _____

SOURCE PATIENT INFORMATION

Full Legal Name: _____

Current location of source patient: _____

Medical Record Number:_____

Date of Birth/Age:_____

Home Address: _____

_____

Home telephone _____ Other contact number _____

If someone other than source patient interviewed/gave HIV consent, complete the following:

Name: _____

Relationship to source patient _____

Home Address: _____

_____

Home Telephone: _____

Pre-Test Counseling:

- ❒ Declined
- ❒ Completed, including , at a minimum, the following information:
  1. Nature and reliability of the test being proposed
  2. Person to whom the results may be disclosed
  3. The purpose for which the test results may be used
  4. Any reasonable foreseeable risks and benefits resulting from test
  5. Information on good preventive practices and risk reduction plans as appropriate
  6. The person's questions and concerns pertaining to HIV test results and the social, emotional and legal consequences

_____ _____

Signature of healthcare provider obtaining source risk assessment and consent Date

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EHS Clinicians Only:

Test Results: Hepatitis B Surface Antigen:_____ Hepatitis C Antibody: _____

HIV Antibody: _____ Results forwarded to patient designated recipient: _____

Signature of EHS Clinician: _____ Date: _____

(Originals- page 1 & 2- to EHS via interoffice/leave in AIM PA office)