FOR OFFICIAL USE ONLY (FOUO) - PRIVACY SENSITIVE INFORMATION

BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN
SOURCE PATIENT RISK FACTOR STATUS

Source Patient Name: _____ Date: _____

Date of birth: _____ Clinic / Ward of Source Patient: _____

A. HIV (Check applicable status):

- ☐ POSITIVE
- ☐ UNKNOWN
- ☐ NEGATIVE *if negative, what was the last HIV test date: _____

B. HEPATITIS B (Check applicable status):

- ☐ INFECTED or CHRONIC CARRIER
- ☐ NOT VACCINATED or UNKNOWN
- ☐ VACCINATED (3x series)

*if vaccinated, does source have a documented, positive Hep B surface antibody test?

☐ YES (date _____) ☐ NO

C. HEPATITIS C (Check applicable status):

- ☐ POSITIVE
- ☐ UNKNOWN
- ☐ NEGATIVE *if negative, what was the last HEP C Antibody test date: _____

D. SOURCE RISK FACTORS for HIV, HEP B / C:

Does this source have any of the following risk factors (check as applicable)?

- Hemophilia or hemodialysis patient? . . . . . ☐ YES ☐ NO
- Received blood transfusions (or products) in the USA before 1992, or ever in a third-world country? . . . . . ☐ YES ☐ NO
- Lived with a chronic carrier of the Hepatitis B or C virus? . . . . . ☐ YES ☐ NO
- Used illegal intravenous drugs? . . . . . ☐ YES ☐ NO
- Has had a sexually transmitted infection? . . . . . ☐ YES ☐ NO
- Has had unprotected sex with a potentially infected person (e.g., a person with a risk factor listed above, a person with multiple sexual partners, or a man who has had sex with a man)?. . . . . ☐ YES ☐ NO

Nurse of the Day (NOD) or Clinic Supervisor:
Hand-deliver this form to provider treating the exposed staff member/patient.

Exposed Staff Member Name: _____ Division: _____

Exposed Staff Member's immediate Supervisor's email: _____

Printed Name of NOD/supervisor: _____ Date: _____

Signature of the NOD/supervisor: _____ Pager: _____

Urgent Care Provider:
Hand-deliver this form to Occ Med, or fax it and shred original.

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