METHODIST UNIVERSITY

INCIDENT REPORT FORM

For an Occupational Bloodborne Pathogen Exposure

Report Date_____

Last Name: _____ First Name_____

Address_____

MU department or program you are enrolled in: _____

Supervisor/Clinical Instructor:_____

Date of incident: _____ Time of incident:_____

Facility and specific location of incident: _____

Job description (description of general duties) :_____

Potentially infectious material involved (e.g. blood etc.):_____

Source of potentially infectious material (e.g. needle-stick, cut, bite etc.)_____

Circumstances surrounding exposure (e.g. work being performed) _____

_____

Route of exposure (e.g. stick, splash, etc.)_____

_____

How exposure occurred (e.g. equipment malfunction) _____

_____

Personal protection equipment worn at time of incident _____

_____

Actions taken at time of incident (e.g. soap/water clean-up, reporting etc.) _____

_____

_____

Recommendations for avoiding repetition: _____

METHODIST UNIVERSITY

Source Individual's Consent or Refusal Form

For HIV, HBV, and HCV Infectivity Testing

Source Individual is the person whose blood or bodily fluids provided the source of exposure.

Note: Complete this form and submit to the health care professional and Methodist University Student health.

Exposed Individual's Information

Name (Please Print):_____

Methodist University Program: _____

Telephone Number: _____

Exposure Date: _____

Source Individual's Statement of Understanding

I understand that employers are required by law to attempt to obtain consent for HIV, HBV, and HCV infectivity testing each time an employee is exposed to the blood or bodily fluids of any individual. I understand that a Methodist University student intern or employee has been accidentally exposed to my blood or bodily fluids and that testing for HIV, HBV, and HCV infectivity is requested. I am not required to give my consent, but if I do, my blood will be tested for these viruses at no expense to me.

I have been informed that the test to detect whether or not I have HIV antibodies is not completely reliable. This test can produce a false positive result when HIV antibody is not present and that follow-up test may be required.

I understand that the results of these tests will be kept confidential and will only be released to medical personnel directly responsible for my care and treatment, to the exposed health care worker for his or her medical benefit and only to others as required by law.

Consent or Refusal & Signature

I hereby consent to:

HIV Testing_____

HBC Testing_____

HCV Testing_____

I hereby ***refuse*** consent to:

HIV Testing:_____

HBC Testing:_____

HCV Testing:_____

Source Individual Identification

Source individual's printed name:_____

Source individual's signature:_____

Date signed:_____

Relationship (if signed by other than source individual):_____

METHODIST UNIVERSITY

Refusal of Post-Exposure Medical Evaluation

For Bloodborne Pathogen Exposure

Supervisor or Clinical Instructor: Print and complete this form only if the exposed individual refuses post-exposure medical evaluation by a health care professional. Send this completed form to Methodist University Student Health.

Exposed Individual Information
Please print

Last Name: _____ First Name: _____

Student ID: _____

Methodist University Department/Program: _____

Exposure Date: _____

Exposure Information

Facility and Department where the incident occurred: _____

Type of protection equipment used (gloves, mask, etc.): _____

Describe how you were exposed: _____

_____

_____

Explain how to prevent this type of expose: _____

_____

_____

Statement of Understanding

I have been fully trained in Methodist University's Bloodborne Pathogen Exposure Control Plan, and I understand I may have contracted an infectious disease such as HIV, HCV, or HBV. I also understand the implications of contracting these diseases.

I have been offered follow-up medical testing to determine whether or not I contracted an infectious disease such as HIV, HCV, or HBV. I also have been offered follow-up medical care in the form of counseling and medical evaluation of any acute febrile illness (new illness accompanied by fever) that occurs within twelve weeks pot-exposure.

Despite all of the information I have received, for personal reasons, I freely decline this post-exposure evaluation and follow-up care.

Exposed Individual's Signature: _____ Date: _____

Witness Name: _____ Signature: _____