

SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

BLOODBORNE PATHOGEN

POST EXPOSURE – INCIDENT REPORT

Name of Exposed Employee: _____ SSN: _____

Date of Incident: _____ Time of Incident: _____ A.M. P.M.

Name of Source Individual (in known): _____

Describe the circumstances of exposure incident: _____

Describe the potential exposure including route of exposure: _____

Describe precautions taken to prevent exposure including P.P.E. used: _____

Medical counseling; opportunity for HBV and HIV testing; Hepatitis B vaccinations, and follow-up evaluation including prophylaxis made available to employee and these services were (Accepted) (Declined)

Comments: _____

Completed by: _____
Employee Date

Program Supervisor Date

***TO BE COMPLETED BY THE CENTER NURSE**

Assessment of Potential Exposure: _____

Is Hepatitis B vaccination indicated for this employee? _____

Has employee received Hepatitis B vaccination? _____

Employee referred to: _____ (Physician) on _____ at _____

Signed: _____ Licensed Healthcare Professional

*Original to Personnel Specialist, copies to employee and physician.