

NAME		<input type="checkbox"/> MALE  <input type="checkbox"/> FEMALE	PID _____
			-or- ZPED _____
ADDRESS		DOB MONTH DAY YEAR	
PHONE w: (     ) h: (     )	EMAIL	COLLEGE/DEPARTMENT/PROGRAM  CLINICAL ROTATION SITE	

EXPOSURE DATE month day year	EXPOSURE TIME _____ A.M. or P.M.	FACILITY & CITY OF EXPOSURE _____ CLINICAL CONTACT/ SITE SUPERVISOR _____ PHONE _____
---------------------------------	-------------------------------------	---

**TYPE OF EXPOSURE**

<b>MUCOUS MEMBRANE</b> _____ Eye _____ Mouth _____ Nose	<b>PERCUTANEOUS</b> _____ Blood Draw / Type of Needle _____ _____ IV Start / Type of Needle _____ _____ During Surgery / Type of Needle, Instrument _____ _____ IV Piggyback – Visible Blood in Tubing _____ _____ Other Needle Stick / Type of Needle _____ _____ Other (laceration, abrasion, etc.)	<b>RESPIRATORY</b> _____ Resp	<b>SKIN</b> _____ Open Sore, Wound, Scratch, Lesions _____ Hangnail _____ Eczema
--	---	----------------------------------	--

DURATION OF EXPOSURE \_\_\_\_\_ Seconds / Minutes / Hours      EXTENT / DEPTH OF EXPOSURE \_\_\_\_\_

IN DETAIL, DESCRIBE HOW EXPOSURE OCCURRED (route, circumstances, precautions in place, specific injury, extent of exposure, etc.)

---



---



---



---



---



---

(GO TO PAGE 2 TO COMPLETE FORM)

**SOURCE PATIENT RISK ASSESSMENT**

SOURCE PATIENT KNOWN POSITIVE:

YES  NO  UNKNOWN

If yes, please specify:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HIV Viral Load If known \_\_\_\_\_

OTHER KNOWN RISK FACTORS FROM SOURCE

\_\_\_\_\_ Blood Transfusions (prior to 1992)  
\_\_\_\_\_ History of High Risk Sexual Behavior  
\_\_\_\_\_ Previous or Current Injectable Drug Use  
\_\_\_\_\_ Other (SPECIFY)

**ACTIONS TAKEN AS A RESULT OF EXPOSURE**

GUIDELINES REVIEWED  YES  NO

SITE OF INITIAL ASSESSMENT AND CARE  NONE

SELF CARE ADMINISTERED (SPECIFY)  NONE

**POST-EXPOSURE TREATMENT**

NO TREATMENT RECOMMENDED

TREATMENT RECOMMENDED (SPECIFY)

TREATMENT RECEIVED (SPECIFY) DATE TREATMENT INITIATED \_\_\_\_\_

FOLLOW UP NEEDED?

NO

YES (SPECIFY)

FOLLOW UP DATE \_\_\_\_\_ FOLLOW UP LOCATION \_\_\_\_\_

BY SIGNING BELOW, I INDICATE THAT I UNDERSTAND THIS FORM WILL BE KEPT CONFIDENTIAL. I ALSO UNDERSTAND THAT ADMINISTRATORS (OR THEIR DESIGNEES) FROM MY COLLEGE/DEPARTMENT OR PROGRAM, THE OFFICE OF THE UNIVERSITY PHYSICIAN, AND THE OCCUPATIONAL HEALTH SERVICE WILL ALSO REVIEW THIS FORM.

STUDENT SIGNATURE \_\_\_\_\_ | \_\_\_\_\_ DATE: \_\_\_\_\_  
(print) (signature)

PREPARER'S SIGNATURE \_\_\_\_\_ | \_\_\_\_\_ DATE: \_\_\_\_\_  
(print) (signature)

COLLEGE / DEPT / PROGRAM ADMINISTRATOR: \_\_\_\_\_ | \_\_\_\_\_ DATE: \_\_\_\_\_  
(print) (signature)

RETURN COMPLETED FORM TO THE ADDRESS OR FAX NUMBER BELOW

Occupational Health Nurse • MSU Occupational Health Srvc • Olin Health Center • East Lansing, MI 48824-1037 • 517.355.0332

**DO NOT COPY THIS FORM**