MICHIGAN STATE UNIVERSITY

HEALTH PROFESSIONS STUDENTS EXPOSURE REPORT

for Tuberculosis, Blood Borne Pathogens and Zoonotic Disease

NAME	☐ MALE ☐ FEMALE	PID _____ -or- ZPED _____
ADDRESS		DOB MONTH DAY YEAR
PHONE w: ( ) h: ( )	EMAIL	COLLEGE/DEPARTMENT/PROGRAM CLINICAL ROTATION SITE

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

TYPE OF EXPOSURE

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

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 ADMINSTRATORS (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