

INSTRUCTIONS
Oklahoma State Department of Health
Communicable Disease Risk Exposure Report

This report form was developed to initiate a system of notification for risk exposures occurring outside of a health care facility to health care workers, emergency responders, and funeral workers as specified by the Oklahoma State Department of Health OAC 310:555. This report and all information entered on it are to be held in strictest confidence to conform with 63 O.S. Supp. 2001, Section 1-502.1 et. seq.

Note: For questions regarding the handling of ODH Form 207, call 405/271-4636.

PART I: Exposed Worker Section

Questions 1-13 are to be completed by the exposed worker, immediately following the injury.

- 11: Describe exposure in detail. Include information regarding type of exposure, body part affected, type of body fluid involved, duration of exposure, etc.
- 13: List the facility where the source patient was taken. This will be the facility that is responsible for testing the source patient.

Questions 14-19 are to be completed by Employer's Designee, immediately following the injury.

Questions 20-22 are to be completed by a Licensed Health Care Professional. (MD, DO, RN, PA,).

Routing:

- A. If the Licensed Health Care Professional determines that the exposure does not have the potential for transmission of a communicable disease, the form should be returned to the Employer's Designee.
- B. If the exposure does have the potential for transmission of a communicable disease, the *Yellow* copy should be mailed *immediately* to the OSDH HIV/STD Service (use gray, self addressed, metered envelope).

The *Green* copy, a gray metered envelope and instruction page are to be delivered *immediately* to the designated person (usually the Infection Control Practitioner) at the health care facility to which the source patient was transported; to the attending physician, if the source patient was being cared for outside of a health care facility; to the health care provider who last had responsibility for the deceased source patient; or to the medical examiner.

PART II: Source Patient Health Care Provider Section

Questions 23-38 are to be completed by the Health Care Provider who is responsible for testing the source patient.

- 32. Rapid HIV testing has become a valuable tool used to quickly determine the need for initiation and/or continuation of PEP meds for the exposed person. When a rapid HIV test is performed on the source patient, communication of these results should not be delayed. The results should be **immediately** communicated to the physician/provider who is providing post-exposure counseling and follow up and is listed on page 1, q. 17-19.

Please note that as other source results become available, these should be released to the Provider listed on page 1, q. 17-19.

Routing:

- A. The Health Care Provider should complete Part II and mail the completed green form to OSDH HIV/STD Service immediately using the gray, self-addressed, metered envelope.

PART II: Source Patient Health Care Provider Section (Please Print)

23. Date and time Communicable Disease Risk Exposure Report received: (Mo./Day/Yr.) ____/____/____ Time: ____AM or PM (Circle One)

24. Person completing Part II: _____
(Last) (First) (Title)

25. Institution (name): _____ Business Phone: (____) _____

Source Patient Information

26. Birth date: (Mo./Day/Yr.) ____/____/____ 27. Sex: Male; Female

28. Primary Diagnoses: _____

29. Was the source patient found to have any potentially communicable disease(s), such as hepatitis B, hepatitis C, HIV, TB, meningococcal disease, or others? Yes No

30. If yes, specify: _____

31. Does the source patient have clinical evidence of AIDS or symptoms of HIV infection or acute retroviral syndrome? Yes; No; Unknown

Source Patient Test Results

32. Rapid HIV test: Positive; Negative; Indeterminant Test Date: (Mo./Day/Yr.) ____/____/____ Not Done

Note: IMMEDIATELY report Rapid HIV results by phone or fax to the Provider listed on page 1, q. 17-19. As other test results become available, these are also to be released to the Provider listed on page 1, q. 17-19.

33. HBsAg: Positive; Negative Test Date: (Mo./Day/Yr.) ____/____/____ Not Done

34. anti-HCV: Positive; Negative Test Date: (Mo./Day/Yr.) ____/____/____ Not Done

35. HIV: Positive; Negative; Indeterminant Test Date: (Mo./Day/Yr.) ____/____/____ Not Done

36. Other: Name of Test: _____ Test result: _____ Test Date: (Mo./Day/Yr.) ____/____/____

Note: Source results may be released to the source patient; the exposed person; the exposed person's physician/provider or OSDH per OAC 310:555.

37. Date results released to Provider: (Mo./Day/Yr.) ____/____/____ 38. Date mailed to OSDH: (Mo./Day/Yr.) ____/____/____

When Part II is completed, mail immediately to the OSDH HIV/STD Service using the gray, self-addressed, metered envelope.

Part III: OSDH Section (Please Print)

Date Report Received: (Mo./Day/Yr.) ____/____/____ Person Completing Part III: _____
(Last) (First)

OSDH Division: _____

Follow-Up Action: _____

Communicable Disease Risk Exposure Report

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PART I: Exposed Worker Section (Please Print)

1. Employee Name: _____ 2. Birth date: ____/____/____
(Last) (First) (MI) Mo. Day Yr.

3. Home Telephone: (____) _____ 4. Profession/Job Title: _____

5. Employer/Company Name: _____

6. Work Address/Telephone: _____ (____)
(Street) (City) (Zip) Telephone

7. Number of hepatitis B vaccinations previously received: None; 1; 2; 3

8. Date of Exposure: (Mo./Day/Yr.) ____/____/____ 9. Time of Exposure: _____ AM or PM (Circle One)

10. Supervisor's Name/Telephone: _____ (____)
Telephone

11. Description of Exposure: _____

12. Source Patient Name: _____
(Last) (First) (M.I.)

13. Location of Source Patient (include name of facility, address and phone number): _____

To Be Completed By Employer's Designee

I have reviewed the circumstances and management of this incident and verify that the appropriate follow-up (according to our agency Exposure Control Plan) is being attempted in order to identify or prevent the transmission of communicable diseases to which the employee may be at risk as a result of this exposure.

14. _____ 15. _____ 16. ____/____/____
Name & Title (Print) Signature Mo. Day Yr.

Post-exposure counseling and follow-up will be provided to this employee by:

17. _____ 18. (____) _____ 19. (____)
Provider's Name Provider's Telephone Number Provider's Fax Number

To Be Completed by A Licensed Health Care Professional (MD, DO, RN, PA,)

In my professional judgment, this was was not a mucosal, percutaneous or respiratory exposure that has the potential for transmission of a communicable disease, such as hepatitis B, hepatitis C, HIV, TB or meningococcus.

20. _____ 21. _____ 22. ____/____/____
Name & Title (Print) Signature Mo. Day Yr.

For consultation regarding exposures and PEP meds: PEP Hotline 1-888-448-4911

Note: If this exposure does not warrant medical follow-up, please return the form to the *Employer's Designee* and indicate to that individual why no follow-up is required.

If this is an exposure that warrants medical follow-up, the employer shall handle the report accordingly:

- A. **Yellow** copy to be mailed *Immediately* to the OSDH HIV/STD Service (use gray, self-addressed, metered envelope) at 1000 N.E. 10, OKC, Ok 73110
- B. **Green** copy, a gray metered envelope and instruction page to be delivered *immediately* to the designated person (usually the Infection Control Practitioner) at the location of the source patient.