POST EXPOSURE MEDICAL EVALUATION FORM

Organization Name:_____ Address: _____

Employee Name: _____

Date of Exposure: _____ Time: _____

Route(s) and circumstances of exposure: _____

_____

_____

Employee's duties as they relate to exposure incident: _____

_____

_____

Employee vaccination status (include dates) _____

Results of the source individuals blood testing

HIV _____ HBV _____ Not Available _____

_____

Please find attached:

_____ A copy of OSHA Blood-borne Pathogens Regulations

_____ Employee's Medical records relevant to appropriate treatment

_____ Consent forms

Results of medical evaluation

Health care professional's written opinion:
(This must be completed within 15 days of the completion of the evaluation, and given to the employer. Do not include other diagnosis or findings in this report.)

_____

_____

Exposed individual current laboratory data will be maintained by the physician.

(Of employee does not give consent at this time for HIV serologic testing, the sample shall be preserved for at least 90 days.)

Is Hepatitis vaccination indicated for this employee? _____

_____

Was such a vaccine received? _____

Is post exposure prophylaxis medically indicated as recommended by the U.S. Public Health Services?

_____

Treatment given: _____

_____

_____

_____

Follow up recommended: _____

_____

_____

The employee has been informed of the results of the evaluation, and has been told about any medical condition resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

Physician Signature: _____ Date: _____

I have reviewed the above information and received counseling from the physician. I have received a copy of this report.