# INCIDENT REPORTS

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INCIDENT REPORTS

Function/Purpose

An incident report is not part of the patient’s chart, but it may be used later in litigation. A report has two functions:

1. It informs the administration of the incident so management can prevent similar incidents in the future.
2. It alerts administration and the facility’s insurance company to a potential claim and the need for investigation.

Regulations issued under OSHA require all employers with more than ten employees at any time during the previous calendar year to maintain records of recordable occupational injuries and illnesses.

# When to Report

Incidents that must be reported and documented include:

1. Exposure Incidents: skin, eye, mucous membrane or parental contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.
2. Accident, Injury: patient, visitor, employee slips or falls, or other incident, which results or may result in injury.
3. Event, Behaviors, or Actions: incidents that are unusual, contrary to agency policy or procedure or which may result in injury.
4. Vaccine Adverse Event Reporting System: reaction to vaccine administered at agency (use VAERS form, instructions and sample in Immunization section).
5. Medication reaction: reaction to any drug administered at or provided by health department. Complete Adverse Drug Reaction Form. For more information,

 call 1-800-332-1088.

1. Property damage or missing articles.
2. Administration of wrong medication or vaccine.
3. Improper administration of medication or vaccine.

#

# OSHA Recordkeeping Requirements

OSHA 300 Log-recordable and nonrecordable injuries are distinguished by the treatment provided; i.e., if the injury required medical treatment, it is recordable; if only first aid was required, it is not required, it is not recordable. However, medical treatment is only one of several criteria for determining recordability. Regardless of treatment, if the injury involved loss of consciousness, restriction of work or motion, transfer to another job or termination of employment, the injury is recordable. An explanation, with examples, is included on the backside of the OSHA 300 Form.

# Who Should Report

Only people who witness the incident should fill out and sign the incident report. Each witness should file a separate report. Once the report is filed, the nursing supervisor, department heads, administration, the facility’s attorney, and the insurance company may review it.

Because incident reports will be read by many people and may even turn up in court, you must follow strict guidelines when completing them. If an incident report form does not leave enough space to fully describe an incident, attach an additional page of comments.

Document the incident as it occurred in the patient’s medical record, “Incident Report Completed” should never appear in the patient’s record. The incident report should never be referred to in any way in the medical record.

# Employee Responsibility

All employees are responsible for preparing an incident report as soon as possible and reporting immediately to their supervisor or in the supervisors absence report to the administration any incident or injury including near misses. Recommendations and appropriate changes shall be discussed with the supervisor and necessary corrections implemented to prevent further accidents.

# Supervisor Responsibility

Upon receiving a report of an incident, written or oral, the supervisor shall conduct an investigation. Following the investigation, supervisors are to review and complete the Incident Report and initiate Worker Compensation Report if indicated for the LHDs insurance carrier. The supervisor shall take action to implement corrective measures immediately when the investigation reveals such actions are necessary.

The supervisor shall provide a copy of the Incident Report and the Worker’s Compensation Report (if necessary) to the LHDs Safety Officer within five working days of the accident.

Reports of all incidents and near misses should be discussed during meetings with employees of the work unit to prevent problems of the same nature in the future.

# Tips for Reporting Incidents:

1. Include essential information, such as identity of the person involved in the incident, the exact time and place of the incident and the name of the doctor you notified.
2. Document any unusual occurrences that you witnessed.
3. Record the events and the consequences for the patient in enough detail that administrators can decide whether or not to investigate further.
4. Write objectively, avoiding opinions, judgments, conclusions, or assumptions about who or what caused the incident. Tell your opinions to your supervisor later.
5. Describe only what you saw and heard and the actions you took to provide care at the scene. Unless you saw a patient fall, write “found patient lying on the floor”.
6. Do not admit that you are at fault or blame someone else. Steer clear of statements like “better staffing would have prevented this incident”.
7. Do not offer suggestions about how to prevent the incident from happening again.
8. Do not include detailed statements from witnesses and descriptions of remedial action; these are normally part of an investigative follow-up.
9. Do not put the report in the medical record. Send it to the person designated to review it according to your facility’s policy.

From the book *“Charting Made Incredibly Easy”* Springhouse Corporation.

The following are SAMPLE copies of “Incident/Complaint Report”, “Laboratory Incident Report”, Employee Consent for Blood Testing-Post Exposure”, and “Patient Consent for Blood Testing-Post Exposure”. Some agencies may use incident reports supplied or recommended by their insurance carrier.

INSTRUCTIONS FOR COMPLETION OF FORM

The Complaint/Incident Form is to be used to document the following:

1. Any type of accident, vehicle or otherwise, which may or may not involve injuries.
2. Patient – provider conflicts.
3. Employee conflicts.
4. Complaints.

When reporting a complaint/incident follow these steps:

1. Complete the form and obtain appropriate signatures.
2. Submit the original form to the district office within five working days.
3. If a copy is kept at the local office, it must be filed in a locked cabinet.

If any further assistance is needed, please contact your discipline director.

INCIDENT/COMPLAINT REPORT

EMPLOYEE: Return this COMPLETED FORM to your SUPERVISOR as soon as possible.

Name of Person Involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M \_\_\_\_ F \_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_ am/pm

Exact Location of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Type of Accident: Check:

* Clerical/Data Entry \_\_\_\_\_ Patient
* Communications \_\_\_\_\_ Employee
* Testing Process \_\_\_\_\_ Visitor
* Result reporting \_\_\_\_\_ Volunteer
* Safety \_\_\_\_\_ Other
* Medical Device Failure
* Policy/Procedural Violations
* Adverse Drug Reaction
* Vehicle Accident
* Needlestick
* Exposure to Hazardous Substance
* Medication Error (Wrong: Route, Dosage, Medication, Schedule)

EMPLOYEE: Involved \_\_\_\_\_ yes \_\_\_\_\_ no

Were they doing their regular job duties: \_\_\_\_\_ yes \_\_\_\_\_ no Observed by employee yes

Hire Date: \_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_ Situation observed only by employee yes

Employee Classification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Protective Equipment being used: \_\_\_\_\_ yes \_\_\_\_\_ no

If not used, why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Description of Incident/Complaint (Who, what, Where, How, why, Include sequence of events, personnel involved, body part injured, reason incident occurred) (If medication error include brand name, manufacturer, dosage) (Use additional form if necessary)

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Actions Taken by Staff Members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL FOLLOW-UP:** Was Medical Attention Sought: \_\_\_\_\_ yes \_\_\_\_\_ no

Treatment Refused: \_\_\_\_\_ yes \_\_\_\_\_ no First Treatment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Day Off Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return to Work Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duties Restricted: \_\_\_\_\_ yes \_\_\_\_\_ no Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INCIDENT/COMPLAINT REPORT

Incident Reported By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Notified: \_\_\_\_\_ yes \_\_\_\_\_ no Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature and Title of Person Preparing Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Supervisor Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Corrective Action Taken/Follow-Up: (Things that have been or will be taken to prevent recurrence)

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

Director Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Nursing Administrator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Administrator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Signature of Person making Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Worker Compensation first Report Sent: \_\_\_\_\_ yes \_\_\_\_\_ no Date: \_\_\_\_\_\_\_ OSHA 300 Log # : \_\_\_\_\_\_

\_\_\_\_\_ I understand the potential risks related to the exposure to the incident that occurred and agree to receive an examination and/or treatment for the exposure, as recommended by my physician. This includes serological testing for Hepatitis B and the HIV virus as indicated.

\_\_\_\_\_ I understand the potential risks related to the exposure incidents that occurred and DO NOT agree to have an examination or treatment for the exposure.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

I understand the information above will be used by my employer to help determine liability for injury. I acknowledge that the above statements are true and accurate representation of the requested information.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Testing for HBV: Baseline and 6 months\*

Testing for HIV: Baseline, 6 weeks, 3 months, 6 months, and 1 year\*\*

Current references may be found on the CDC website: [www.cdc.gov](http://www.cdc.gov) “(Morbidity and Mortality Weekly Report [MMWR], June 29, 2001/Vol.50/No.RR-11 or latest version”; Morbidity and Mortality Weekly Report [MMWR], September 30, 2005/Vol.54/No. RR-9, update)

**LABORATORY INCIDENT REPORT**

***Document the incident:*** Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Department Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who was involved?

* In-house
* External, person involved (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did it happen?

Date of incident \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did the incident come to your attention?

* Was involved
* Reported to me
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of incident:

* Clerical/Data Entry ❒ Testing Process ❒ Other \_\_\_\_\_\_\_\_\_\_\_\_
* Communications ❒ Result Reporting
* Proficiency Testing ❒ Safety

Describe the incident: (include multiple versions when applicable)

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

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Incident Reported By:

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

Signature Date

**Initial Review Process:** (To be completed by the Local Supervisor and/or Co-director and other essential personnel, as needed. Briefly describe the outcome of the incident investigation, include any necessary plan of corrective action or any policy change to be implemented.)

Reviewer’s summary\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Laboratory Director’s Review:** (Following the initial local review and evaluation, please copy to the State Lab Director for review.)

Director’s summary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Follow-up Review:** (To be performed 3 months from the initial date filed. After the remedial action has been monitored and evaluated for effectiveness. If the incident has not been satisfactorily resolved, the Supervisor and/or Co-director should repeat the Initial Review Section, performing monthly reviews, and additional remedial action until satisfactory resolution is attained.)

Has the Incident recurred since the Initial Review?

 ❑ YES

 ❑ NO

Follow-up Reviewer’s summary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Filing the FINISHED Report:

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## POST-EXPOSURE INCIDENT

## SOURCE INDIVIDUAL CONSENT FORM

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Name (PLEASE PRINT) Social Security Number

# Informed Consent to Blood Testing

I have been informed that an individual has been exposed to my blood or body fluids. As a result of the exposure, I have been asked to permit my blood to be tested for HIV (known to cause AIDS), HBV and HCV.

(Check One)

* I hereby give my consent to such testing.
* I consent to have my blood tested for HBV, but I decline to have my blood tested for HIV at this time. I understand that by choosing this option, a sample of my blood will be kept for 90 days, during which period I may change my mind and have my blood tested for HIV at that time.

My consent is based on the understanding that:

* 1. My test results will remain confidential and provided only to those who have a need to know in accordance with current federal, state, and local statutes.
	2. I have been provided with information concerning HIV and HBV, and understand the contents thereof.
	3. I have been given the opportunity to ask questions concerning HIV and HBV testing.
	4. I will receive a copy of all test results.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signed Date

**Employer’s Representative**

I certify that the above-named individual received a copy of the HIV/HBV information sheets and has had the contents thereof fully explained.

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Date Employer’s Representative (PLEASE PRINT)

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

 Title

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

 Signature

This document will be retained in the exposed employee’s medical file.

**POST-EXPOSURE INCIDENT**

**EXPOSED EMPLOYEE CONSENT FORM**

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Employee Name (PLEASE PRINT) Social Security Number

**Employee Consent to Blood Testing**

As a result of my exposure to blood or other potentially infectious material, it is recommended that I have my blood tested for HIV (known to cause AIDS), HBV and HCV.

(Check One)

* I hereby give my consent to such testing.
* I consent to have my blood tested for HBV, but I decline to have my blood tested for HIV at this time. I understand that by choosing this option, a sample of my blood will be kept for 90 days, during which period I may change my mind and have my blood tested for HIV at that time.

My consent is based on the understanding that:

* 1. My test results will remain confidential and provided only to those who have a need to know in accordance with current federal, state, and local statutes.
	2. I will be provided with counseling whether the tests are negative or positive.
	3. I have been provided with information concerning HIV and HBV, and understand the contents thereof.
	4. I have been given the opportunity to ask questions concerning HIV and HBV testing.
	5. I have received risk behavior guidelines concerning HIV.
	6. I will receive a copy of all test results.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signed Date

**Employer’s Representative**

I certify that the above-named individual received a copy of the HIV/HBV information sheets and has had the contents thereof fully explained.

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Date Employer’s Representative (PLEASE PRINT)

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 Title

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 Signature

This document will be retained in the exposed employee’s medical file.