OPEN DOOR COMMUNITY HEALTH CENTERS

POST EXPOSURE PROTOCOL

FOR USE WITH

SHARPS INJURIES, NEEDLE STICKS & OTHER BODY SUBSTANCE EXPOSURES

SITE OF INCIDENT

☐-BURRE DENTAL CENTER
☐-DEL NORTE COMMUNITY HEALTH CENTER – DENTAL
☐-DEL NORTE COMMUNITY HEALTH CENTER – MEDICAL
☐-EUREKA COMMUNITY HEALTH CENTER
☐-HUMBOLDT OPEN DOOR CLINIC
☐-McKINLEYVILLE COMMUNITY HEALTH CENTER
☐-McKINLEYVILLE COMMUNITY HEALTH CENTER – PEDIATRICS
☐-MOBILE DENTAL – HUMBOLDT
☐-MOBILE DENTAL – DEL NORTE
☐-MOBILE MEDICAL OFFICE
☐-NORTHCOUNTRY CLINIC
☐-PERINATAL SERVICES OF NORTHCOUNTRY CLINIC
☐-TELEHEALTH & VISITING SPECIALIST CENTER
☐-WILLOW CREEK COMMUNITY HEALTH CENTER – DENTAL
☐-WILLOW CREEK COMMUNITY HEALTH CENTER – MEDICAL

☐-OTHER (SPECIFY): _____

DATE OF INCIDENT

_____
Month/Day/Year

PERSON REPORTING INCIDENT

_____
Name and Title

DATE OF THIS REPORT

_____
Month/Day/Year

☐-SITE WHICH CONDUCTS EXAM, TESTS AND EVALUATIONS SHOULD KEEP ORIGINAL OF THIS PACKET IN PATIENT'S MEDICAL RECORD (create chart if necessary).

☐-IF EMPLOYEE IS A PATIENT OF ANOTHER ODCHC CLINIC, A COPY SHOULD BE SENT TO THAT CLINIC.

☐-SEND COPY TO CORPORATE RISK MANAGER AT ADMINISTRATION.

DEFINITION OF BODY SUBSTANCE EXPOSURE: Any skin puncture with a contaminated (used) needle, scalpel, burr or other medical or dental instrument or sharp object (e.g., broken glass) and/or any body substance splash, spill or other contact to the eye, nose, mouth or other mucous membrane or with non-intact skin (i.e., rash, cut, abrasion). While the level of risk varies among different body substances, potentially infectious substances include: blood, urine, feces, saliva, sputum, amniotic fluid, peritoneal fluid, pleural fluid, synovial fluid and body tissue or tissue samples. The visibility of blood in any body substance should be noted and reported to the evaluating provider.

EXPOSURE EVALUATION POLICY: ODCHC requires that any person (employee, patient or visitor) sustaining exposure to body substances be seen immediately by an ODCHC licensed provider. The provider evaluates the person exposed and the source patient for the level of risk associated with the exposure and determines the appropriate treatment for the exposed person as outlined in this protocol.

INITIAL PROTOCOL: When an individual sustains exposure to body substances, the exposed person, other ODCHC employees and the provider are to adhere to this protocol or provide strong documentation regarding any deviations. Providers are encouraged to consult with any of the ODCHC resource persons listed below, with the National Clinician's Post Exposure Prophylaxis Hotline, and to invite one or more of these persons or resources into the conversation and counseling with the exposed person.

PAPERWORK AND DOCUMENTATION: The rapid delivery of appropriate care is ODCHC's first priority. The forms in this packet will assist the provider in gathering the information necessary to determine appropriate post exposure testing and treatment for both the exposed individual and the source patient. In addition, body substance exposure incidents must be documented and reported to a variety of sources. Completing all requested information in this packet will assist both the clinic and administrative reporting requirements.

FOLLOW-UP AND SUPPORT: ODCHC is fortunate to have medical practitioners and registered nurses expert in the area of post-exposure prophylaxis, potential HIV and Hepatitis infection and the use of prophylactic measures to prevent or diminish the likelihood of infection or complication. As a team, the medical practitioner, nurse case manager, laboratory staff and the corporate risk manager will assist exposed individuals through the processes of receiving necessary prophylactic and follow-up services. Counseling and information is available from any of the ODCHC resource people listed below and the PEPLine – available free-of-charge to all ODCHC employees.

ODCHC RESOURCES FOR EMPLOYEES AND PROVIDERS

LIZ CARVER, RN	HIV Nurse Case Manager	DNCHC	465-6925 ....x 6268
SERGIO CODINA, RN	HIV Nurse Case Manager	HODC	826-8610 ....x 1139
DAVID HORWITZ, PA	HIV Program Provider	HODC	826-8610 ....x 1126
GAIL HOVORKA, MD	HIV Program Medical Director	HODC and	826-8610 ....x 1113
		TVSC	442-4038 ....x 3160
CLINT PEARSON, MD	HIV Program Provider	DNCHC	465-6925 ....x 6275
CHRISTOPHER PETERS	Legal Affairs Director	ADMINISTRATION	826-8633 ....x 5132

PEPLINE

NATIONAL CLINICIAN'S POST EXPOSURE PROPHYLAXIS HOTLINE

888-HIV-4911 – 888-448-4911

The PEPLine is open for emergency calls 24 hours a day, 7 days a week (other calls will be returned during business hours). The PEPLine provides information on risk assessment, prophylaxis protocols, testing, HIV, Hepatitis B, Hepatitis C and other Blood Borne Pathogens.

EVALUATION OF EXPOSURE: The exposure should be evaluated for the potential to transmit the Hepatitis B, Hepatitis C and/or HIV virus based on the type of body substance involved and the route and severity of exposure. Blood, body fluids containing blood, or other potentially infectious materials can be transmission routes for infectious disease. Exposure to these fluids or tissues through a needle stick or other penetrating sharps injury or through direct contact with mucous membranes are events that pose the risk for blood borne virus transmission and require further – and immediate – evaluation. Other potentially infectious materials include: semen; vaginal secretions; and, cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids. Common substances such as urine, sweat, saliva and feces are not considered infectious unless they contain visible blood. For Hepatitis C and HIV, exposure to a blood-filled hollow needle or a visible bloody device poses a higher risk than an event where the needle was used to give an injection; however, all sharps injuries require evaluation. For exposure to non-intact skin (non-sharps event), follow-up is indicated only if the exposure involves blood, fluid or other potentially infectious materials containing visible blood, and where there is evidence that the integrity of the skin is compromised (i.e., dermatitis, abrasion or open sore or wound).

IN CASE OF
NEEDLE STICK, OTHER SHARPS INJURY OR OTHER BODY SUBSTANCE EXPOSURE,

IMMEDIATELY

1. **DO NOT HESITATE**, take action, report the incident and get the care you need. There is a limited window of opportunity to assure the effectiveness the prophylactic measures. The longer you take to clean the injury site, report the incident, be evaluated and get started on an appropriate treatment plan, the higher the risk of infection becomes. Don't be embarrassed and don't take chances.

2. **FLOOD AND WASH** the exposed area with water and clean any wound with soap and water and skin disinfectant. If an eye exposure, use EYE WASH STATION FLUID to flush eye(s).

3. **NOTIFY YOUR SITE ADMINISTRATOR, NURSE COORDINATOR OR OFFICE MANAGER** of the incident. Any of these individuals will facilitate implementation of this protocol and make sure you get the care you need.

4. **CONTACT THE TRIAGE NURSE OR FRONT DESK** to arrange for an immediate provider examination. If an injury or exposure occurs at a Dental Center, contact the nearest ODCHC medical clinic for an immediate appointment. If the injury is severe, arrange transport to the nearest hospital emergency room for initial care.

5. **ASK THE SOURCE PATIENT TO REMAIN IN THE CLINIC** as part of the evaluation of the exposure incident (see 5 and 6 below). The "source patient" is the person to whom the employee was exposed (the source of the blood or other body substances) – including those patients receiving injections, blood draws or procedures in which there was a subsequent needle stick or sharps injury with a contaminated syringe, instrument or other sharp object.

6. **HAVE A PROVIDER EVALUATE YOU AND THE EXPOSURE**, completing the "Evaluation: Person Exposed" portion of this packet and determining the need for intervention, lab work and treatment. The provider may need to complete an evaluation of the source patient before being able to properly advise the exposed person.

7. **HAVE A PROVIDER EVALUATE THE SOURCE PATIENT**, completing the "Evaluation: Source Patient" portion of this packet and determining the need for quick test, lab work and treatment. The evaluation of the source patient may need to occur before the provider can properly advise the exposed person.

8. **DEVELOP A TREATMENT PLAN** with the ODCHC provider to determine the need for treatment, prophylactic medications, other medications and follow-up testing.

9. **COMPLETE THE OTHER PAPERWORK** for reporting this workplace injury and send a copy of this packet along with all other related paperwork to the Corporate Risk Manager.

10. **FOLLOW THROUGH** with the recommendations of your provider. You may seek second opinions from other ODCHC providers or the PEPLine but do not delay in seeking medical care and advice.

11. **CONTINUE TO GET TESTED** regularly (at least every three months for the first year) based on the recommendations of your provider and the reminder card provided to you. Any ODCHC will honor your reminder card and get a copy of the standing order the clinic which examined you for your exposure. Testing is the only way to know that you are remaining infection free and the best way to guide necessary follow-up treatment.

EVALUATION: PERSON EXPOSED

Name _____ **DOB** _____ **MR#** _____
Last First M *MM/DD/YY*

Title/Status _____ **If Not Employee** ☐-Patient; ☐-Visitor; ☐-Vendor, ☐-Other

Contact Numbers _____ _____ _____ _____
Office/Clinic Telephone *Extension* *Home Telephone* *Mobile Telephone*

Exposure **Date** _____ **Time** _____ **Clinic Site** _____
MM/DD/YY HH:MM Site Where Exposure Occurred

Examination **Date** _____ **Time** _____ **Clinic Site** _____
MM/DD/YY HH:MM Site Where Evaluation/Examination Occurred

Primary Provider _____ **Consult Provider** _____
Name & Title of Primary Treatment Provider *Name & Title of HIV Team Provider or Nurse Case Manager (if different from Primary)*

IF PENETRATING EXPOSURE

- **Device Type** Needle/Syringe-☐ Large Bore Syringe-☐ Procedure/Surgical Instrument-Dental-☐ Procedure/Surgical Instrument-Medical-☐ Glass/Shard-☐ Other-☐
- **Device Contamination** Unknown-☐ Clean/Known Not To Be Contaminated-☐ Used for Injection-☐ Used for Blood Draw or Tissue Sample-☐ Used for Procedure with Blood/Fluid/Tissue-☐ Used for Suturing-☐ Exposed to Unsanitary Conditions-☐ Other Contamination-☐
- **Contamination Level** Unknown-☐ Appeared Clean-☐ No Visible Blood/Fluid/Tissue-☐ No Visible Blood in Visible Fluid or Tissue-☐ Little Visible Blood/Fluid/Tissue-☐ Some Visible Blood/Fluid/Tissue-☐ Substantial Visible Blood/Fluid/Tissue-☐
- **Penetration** Superficial-☐ Minor Skin Puncture-☐ Moderate Stick or Cut-☐ Deep Stick or Substantial Cut-☐
- **Did Sharp pass through gloves, clothing or other barrier before penetrating skin?** Yes-☐ No-☐

IF MUCOUS MEMBRANE EXPOSURE

- **Membrane Exposed** Eye-☐ Nose-☐ Mouth-☐ Other-☐
- **Type of Body Substance** Blood-☐ Urine-☐ Feces-☐ Sputum, Vomit, Saliva, Sweat-☐ Amniotic, Peritoneal, Pleural, Synovial Fluid-☐ Tissue-☐ Other-☐
- **Amount of Fluid** A Few Drops-☐ < 1 Teaspoon-☐ < 2 Ounces (¼ Cup)- ☐ > 2 Ounces (¼ Cup)- ☐
- **Length of Exposure** < 1 Minute-☐ 1 to 5 Minutes-☐ > 5 Minutes-☐
- **Exposure Type** Direct to Membrane-☐ Direct Through Gap in PPE/Clothing-☐ Soaked Through PPE/Clothing-☐ Other-☐
- **If exposure was to fluids or tissue, was there visible blood in the fluid or tissue?** Yes-☐ No-☐ Unknown-☐

IF NON-INTACT SKIN EXPOSURE

- **Body Part:** _____
- **Exposure To** Open Wound, Cut, Scab-☐ Chapped Skin, Rash, Dermatitis, Eczema-☐ Abrasion, Scrape-☐
- **Type of Body Substance** Blood-☐ Urine-☐ Feces-☐ Sputum, Vomit, Saliva, Sweat-☐ Amniotic, Peritoneal, Pleural, Synovial Fluid-☐ Tissue-☐ Other-☐
- **Amount of Fluid** A Few Drops-☐ < 1 Teaspoon-☐ < 2 Ounces (¼ Cup)-☐ > 2 Ounces(¼ Cup)-☐
- **Length of Exposure** < 1 Minute-☐ 1 to 5 Minutes-☐ > 5 Minutes-☐
- **Exposure Type** Direct to Skin-☐ Direct Through Gap in PPE/Clothing-☐ Soaked Through PPE/Clothing-☐ Other-☐
- **If exposure was to fluids or tissue, was there visible blood in the fluid or tissue?** Yes-☐ No-☐ Unknown-☐

HBV STATUS Vaccinated? Yes-☐ No-☐

Most Recent Test_____
Results Unknown/Untested-☐ Known Reactor-☐ Known Non-Reactor-☐ Negative-☐ Positive-☐

HCV STATUS Most Recent Test_____
Results Unknown/Untested-☐ Negative-☐ Positive-☐

HIV STATUS Most Recent Test_____
Results Unknown/Untested-☐ Negative-☐ Positive-☐

LAB TESTING OF EXPOSED PERSON: Testing of the exposed person will establish a baseline for decisions about post exposure intervention, treatment and follow-up. Testing will be performed at any ODCHC Laboratory free-of-charge. Exposed persons can be tested only if their consent is voluntary (Page 6). A standard ***EXPOSED PERSON LAB PANEL*** has been established (Page 6). All tests will be automatically ordered/performed with the provider's signature of the order page. The provider may choose to exclude certain tests as appropriate. **If the patient and provider determine that testing is not necessary, provide documentation here:**

EVALUATION: SOURCE PATIENT/SOURCE OF EXPOSURE

☐ **IF THE SOURCE PATIENT IS NOT KNOWN (OR THE SOURCE OF THE EXPOSURE MATERIAL IS NOT KNOWN)**, the exposed person and the provider should evaluate the exposure and its risks on the basis of: the appearance of the instruments, fluids or other means of exposure; the types of patients seen during the day of the exposure; the type of exposure (e.g., puncture, membrane, non-intact skin); and, amount and duration of the exposure. Talk with other staff members for memories of patients or events surrounding the exposure. Staff members should be asked if they remember anything that may help identify the source patient, the source of the exposure, or the level of contamination of a sharps left unattended or otherwise mishandled. If a sharps event occurred because something was left on a tray or in a sink, someone of staff may be able to provide information about how it was used and its level of contamination. In the absence of objective information about the source or source patient, the exposure should be assessed epidemiologically based on where and under what circumstances the exposure occurred for the likelihood or risk of transmission of HBV, HCV and/or HIV.

☐ **IF THE SOURCE PATIENT IS KNOWN BUT REFUSES TO BE INTERVIEWED OR TESTED**, the examining provider may request relevant portions of the source patient's medical or dental chart for review. Of interest should be any test results and/or diagnoses for infectious diseases, as well as documentation or discussion of intravenous drug use, sexually transmitted infections, or other indications of conditions or behaviors which may place the exposed person at risk. The provider should also ask other staff members about the source patient. The exposed person and the provider should evaluate the risk of infection based on a review of this known information. The exposed person and the provider should consider their impressions of the source patient, including demographics, attitude, lifestyle and any other information they may gather from staff and materials available through ODCHC clinics.

COMPLETE THE FOLLOWING WHEN THE SOURCE PATIENT IS KNOWN

Name _____ (Last / First / M) **DOB** _____ (MM/DD/YY) **MR#** _____

If Not Patient, Reason for Being in Clinic: ☐-Accompanying Patient; ☐-Employee; ☐-Visitor; ☐-Vendor; Repair Technician; ☐-Other

Contact Numbers _____ (Office/Work Telephone) _____ (Extension) _____ (Home Telephone) _____ (Mobile Telephone)

Examination **Date** _____ (MM/DD/YY) **Time** _____ (HH:MM) **Clinic Site** _____ (Site Where Evaluation/Examination Occurred)

Primary Provider _____ (Name & Title of Primary Treatment Provider) **Consult Provider** _____ (Name & Title of HIV Team Provider or Nurse Case Manager (if different from Primary))

SOURCE OF EVALUATION INFORMATION Source Patient Interview-☐ Review of Medical Chart-☐ Interview with Clinic Staff-☐ Other-☐

SEXUAL ACTIVITY Unknown-☐ Current Long-Term Monogamous Relationship-☐ Current Long-Term Abstinence-☐ History of Unprotected Sex-☐ History of Multiple Partners-☐ Current Unprotected Sex-☐ Current Multiple Partners-☐

IV DRUG USE Unknown-☐ None/Never-☐ Ancient History-☐ Recent History-☐ Current-☐

HBV STATUS Most Recent Test _____ Results Unknown/Untested-☐ Negative-☐ Positive-☐ Mark If Being Treated for HBV ☐

HCV STATUS Most Recent Test _____ Results Unknown/Untested-☐ Negative-☐ Positive-☐ Mark If Being Treated for HCV ☐

HIV STATUS Most Recent Test Date _____ Results Unknown/Untested☐ Negative☐ Positive☐ Mark If Being Treated for HIV ☐ Current Meds _____ Most Recent Viral Load _____ If Genotypes Done, Resistance To _____

LAB TESTING OF SOURCE PATIENT: If the source patient is known and available, test, even if the patient reports positive status for HBV, HCV or HIV. Definitive testing may eliminate the need for the exposed person to take antiretroviral medications. Testing will be done at any ODCHC lab free-of-charge. The patient must consent voluntarily (Page 7). Unigold Quick Tests are available in all medical and dental clinics for preliminary testing, to be confirmed by a standard EXPOSURE SOURCE LAB PANEL (page 7). All tests on the protocol will be completed upon provider's signature of the order unless the provider specifically excludes certain tests.

LAB ORDERS FOR EXPOSED PERSON

Exposed Person..... _____ **DOB** _____ **MR#**_____
Last First M MM/DD/YY

☐ **EXPOSED PERSON REFERENCE LAB PANEL:** To establish a baseline status as well as guide specific post exposure measures and general health care, the exposed person should be tested using the Exposed Person Reference Lab Panel (see below). All tests on the panel will be performed upon a provider's signature unless specifically excluded (lined through) by the provider. This panel determines baseline status for HBV, HCV and HIV as well as general health (CBC and CMP) conditions for consideration in continuing post exposure measures and follow-up treatment.

CPT CODE	TEST TYPE/NAME	ICD-9 CODE	LAB CODE
87340	**HEP B Sag**	**V01.6**	006510
86704	**HEP B Cab**		006718
86706	**HEP B Sab**		006395
86803	**Hep C ab**		140659
85045	**RPR-VDRL**		012005
86701	**HIV**		083824
85031	**CBC**		005009
80053	**CMP**		322000

ORDERING PROVIDER SIGNATURE	*DATE*

☐ **EXPOSED PERSON REFERENCE LAB FOLLOW-UP TESTS STANDING ORDER:** To monitor disease status and conversion over time, the examining provider should sign the Exposed Person Reference Lab Follow-Up Tests Standing Order (below). A copy should be placed in the exposed person's medical chart and a copy should be kept in the laboratory. The reminder card should be completed and given to the patient. Test results should be forwarded to the examining provider as appropriate to guide decisions regarding follow-up treatment. All tests should be conducted as listed unless excluded (lined through) by the ordering provider. Tests should be conducted every 3 months for one year (more frequently as indicated).

Approximate Date				*Approximate Date*				*Approximate Date*				*Approximate Date*			
CPT	TEST	ICD-9	LAB	CPT	TEST	ICD-9	LAB	CPT	TEST	ICD-9	LAB	CPT	TEST	ICD-9	LAB
87340	**HEP B Sag**	V01.6	006510	87340	**HEP B Sag**	V01.6	006510	87340	**HEP B Sag**	V01.6	006510	87340	**HEP B Sag**	V01.6	006510
86704	**HEP B Cab**		006718	86704	**HEP B Cab**		006718	86704	**HEP B Cab**		006718	86704	**HEP B Cab**		006718
86706	**HEP B Sab**		006395	86706	**HEP B Sab**		006395	86706	**HEP B Sab**		006395	86706	**HEP B Sab**		006395
86803	**HEP C ab**		140659	86803	**HEP C ab**		140659	86803	**HEP C ab**		140659	86803	**HEP C ab**		140659
85045	**RPR-VDRL**		012005	85045	**RPR-VDRL**		012005	85045	**RPR-VDRL**		012005	85045	**RPR-VDRL**		012005
86701	**HIV**		083824	86701	**HIV**		083824	86701	**HIV**		083824	86701	**HIV**		083824
85031	**CBC**		005009	85031	**CBC**		005009	85031	**CBC**		005009	85031	**CBC**		005009
80053	**CMP**		322000	80053	**CMP**		322000	80053	**CMP**		322000	80053	**CMP**		322000

Ordering Provider Signature	*Date*

CONSENT TO TESTING: EXPOSED PERSON

I agree to have my blood tested for the presence of the Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV). I have been informed about and understand the limitations and implications of the tests. I have had a chance to ask questions and the questions have been answered to my satisfaction. I understand that the tests are not foolproof and the results are not guaranteed to accurate; the options for additional testing and second opinions have been explained to me. I have been informed that the tests to be performed required the drawing blood from one of my veins and lightly sticking my finger to obtain a drop of blood. By my signature below, I acknowledge that I have been given information concerning the benefits and risks of this test procedure, that I have been told how I may obtain my test results, and that I voluntarily consent to have my blood drawn and analyzed for the presence of HBV, HCV and HIV.

_____ _____ _____
Patient Printed Name (and relationship if not patient) *Patient Signature* *Date*

I have provided appropriate information and explanations regarding blood testing to detect the presence of HBV, HCV and HIV to the above named patient (and patient representative as appropriate). The patient has indicated to me that he/she understood the information and explanations I provided.

_____ _____ _____
Provider Printed Name *Provider Signature* *Date*

LAB ORDERS FOR SOURCE PATIENT

Source Name..... _____ **DOB** _____ **MR#**_____
Last First M *MM/DD/YY*

☐ **UNIGOLD QUICK TEST:** Under all circumstances the provider should order a Unigold Quick Test to determine HIV status. This is a fingerstick test that will provide accurate preliminary results in 10 minutes. Trained providers, nurses, dental assistants and laboratory staff may administer the Unigold Quick Test and can be used in dental and medical centers upon a provider's order. It is particularly important to complete this test if the patient is uncooperative for other testing, unwilling to go to an ODCHC medical laboratory, unclear about disease status, or indicate high risk behaviors. ***PLEASE DO WHAT YOU CAN TO ENGAGE THE PATIENT IN ALL TESTING.*** The results of this test should be used to guide decisions regarding the use of antiretroviral medications and other prophylactic measures. The average waiting time for the return of results of standard tests from LabCorp may either force unnecessary use of medications or delay the start of necessary measures. While the Unigold Quick Test must be confirmed using the Exposure Source Lab Panel, the Unigold Quick Test assists the immediate decision making process.

CPT CODE	TEST TYPE/NAME	ICD-9 CODE	LAB CODE
IN-HOUSE	**UNIGOLD QUICK TEST**	**V74.5**	N/A

ORDERING PROVIDER SIGNATURE	*DATE*

☐ **EXPOSURE SOURCE REFERENCE LAB PANEL:** Whenever possible the provider should order a complete reference lab panel for the source patient. All tests on the panel will be performed unless specifically excluded (lined through) by the provider below. The results of the panel will not be available for three or four days (typically); however, the quantitative nature of the test results will confirm the Quick Test and guide continued use of post exposure measures, including the use of antiretroviral medications.

CPT CODE	TEST TYPE/NAME	ICD-9 CODE	LAB CODE
87340	**HEP B Sag**	**V74.5**	006510
86704	**HEP B Cab**		006718
86803	**Hep C ab**		140659
85045	**RPR-VDRL**		012005
86701	**HIV**		083824

ORDERING PROVIDER SIGNATURE	*DATE*

CONSENT TO TESTING: SOURCE PATIENT

I agree to have my blood tested for the presence of the Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV). I have been informed about and understand the limitations and implications of the tests. I have had a chance to ask questions and the questions have been answered to my satisfaction. I understand that the tests are not foolproof and the results are not guaranteed to accurate; the options for additional testing and second opinions have been explained to me. I have been informed that the tests to be performed required the drawing blood from one of my veins and lightly sticking my finger to obtain a drop of blood. By my signature below, I acknowledge that I have been given information concerning the benefits and risks of this test procedure, that I have been told how I may obtain my test results, and that I voluntarily consent to have my blood drawn and analyzed for the presence of HBV, HCV and HIV.

_____ _____ _____
Patient Printed Name (and relationship if not patient) *Patient Signature* *Date*

I have provided appropriate information and explanations regarding blood testing to detect the presence of HBV, HCV and HIV to the above named patient (and patient representative as appropriate). The patient has indicated to me that he/she understood the information and explanations I provided.

_____ _____ _____
Provider Printed Name *Provider Signature* *Date*

RECOMMENDED POST EXPOSURE PROPHYLAXIS FOR

HIV – PERCUTANEOUS INJURY EXPOSURE

	HIV STATUS Use Unigold Quick Test to Confirm Patient Reported Status; Follow-Up with Post Exposure Lab Panels				
EXPOSURE TYPE	POSITIVE – CLASS 1[1]	POSITIVE – CLASS 2[2]	STATUS UNKNOWN	SOURCE UNKNOWN	NEGATIVE
Less Severe[3]	• Basic 2 Drug PEP[5]	• Expanded 3 Drug PEP[6]	• Generally No PEP • Consider Basic 2 Drug PEP[5] if source has HIV risk factors	• Generally No PEP • Consider Basic 2 Drug PEP[5] if setting or population has HIV risk factors	• No PEP
More Severe[4]	• Expanded 3 Drug PEP[6]	• Expanded 3 Drug PEP[6]	• Generally No PEP • Consider Basic 2 Drug PEP[5] if source has HIV risk factors	• Generally No PEP • Consider Basic 2 Drug PEP[5] if setting or population has HIV risk factors	• No PEP

RECOMMENDED POST EXPOSURE PROPHYLAXIS FOR

HIV – MUCOUS MEMBRANE AND NON-INTACT SKIN EXPOSURE

	HIV STATUS Use Unigold Quick Test to Confirm Patient Reported Status; Follow-Up with Post Exposure Lab Panels				
EXPOSURE TYPE	POSITIVE – CLASS 1[1]	POSITIVE – CLASS 2[2]	STATUS UNKNOWN	SOURCE UNKNOWN	NEGATIVE
Small Volume[7]	• Consider Basic 2 Drug PEP[5]	• Basic 2 Drug PEP[5]	• Generally No PEP • Consider Basic 2 Drug PEP[5] if source has HIV risk factors	• Generally No PEP • Consider Basic 2 Drug PEP[5] if setting or population has HIV risk factors	• No PEP
Large Volume[8]	• Basic 2 Drug PEP[5]	• Expanded 3 Drug PEP[6]	• Generally No PEP • Consider Basic 2 Drug PEP[5] if source has HIV risk factors	• Generally No PEP • Consider Basic 2 Drug PEP[5] if setting or population has HIV risk factors	• No PEP

RECOMMENDED POST EXPOSURE PROPHYLAXIS FOR

HBV – ANY TYPE OF EXPOSURE

Vaccination and Response Status: EXPOSED PERSON	SOURCE PATIENT HbsAg STATUS		
	SOURCE POSITIVE	STATUS OR SOURCE UNKNOWN	SOURCE NEGATIVE
Unvaccinated	• HBIG x 1 • Initiate HB Vaccine Series	• Initiate HB Vaccine Series	• Initiate HB Vaccine Series
Vaccinated: Known Responder	• No Treatment	• No Treatment	• No Treatment
Vaccinated: Known Non-Responder	• HBIG x 2 • HBIG x 1 and Initiate Revaccination	• If Source or Situation if High Risk, Treat According to "Source Positive" Status	• No Treatment
Vaccinated: Response Unknown	*Test Exposed Person for Anti-HBs* • If Adequate: No Treatment Necessary • If Inadequate: HBIG x 1 and Initiate Revaccination	*Test Exposed Person for Anti-HBs* • If Adequate: No Treatment Necessary • If Inadequate: HBIG x 1 and Initiate Revaccination	• No Treatment

[1] HIV Positive – Class 1: Asymptomatic HIV Infection or Known Low Viral Load (<1,5000 copies/mL).
[2] HIV Positive – Class 2: Symptomatic HIV Infection, AIDS, Acute Seroconversion or Known High Viral Load.
[3] Less Severe: Solid Needle; Needle Used for Injection; Superficial Injury.
[4] More Severe: Large Bore Hollow Needle; Deep Puncture; Visible Blood on Device; Needle Used in Patient's Artery or Vein.
[5] Basic 2 Drug PEP:..... ***COMBIVIR*** (one dose twice a day) plus ***TRUVADA*** (one dose once a day)
[6] Expanded 3 Drug PEP: ..... ***COMBIVIR*** (one dose twice a day) plus ***TRUVADA*** (one dose once a day) plus ***KALETRA*** (two doses twice a day)
[7] Small Volume: A few drops to a teaspoonful in contact for less than 1 minute before washing; consider level of skin integrity.
[8] Large Volume: More than a teaspoonful in contact for more than 1 minutes before washing; consider level of skin integrity.

EXAMINING/EVALUATING PROVIDER NOTES AND TREATMENT PLAN:

CONSULTING PROVIDER/HIV TEAM MEMBER NOTES:

SHARPS INJURY AND BODY SUBSTANCE EXPOSURE REPORT
• TO BE COMPLETED BY THE EXPOSED EMPLOYEE •

To be completed for all exposure incidents, including all sharps injuries, mucous membrane exposures and exposures to non-intact skin.

Employee Name..... _____ (Last / First / M) **Date of Birth**_____ (MM/DD/YY) **Date of Hire** _____ (MM/DD/YY)

Title/Status ..... _____ **Usual Work Dept**_____ **Usual Work Site** _____

Contact Numbers.... _____ (Office/Clinic Telephone) _____ (Extension) _____ (Home Telephone) _____ (Mobile Telephone)

Exposure ..... **Date** _____ (MM/DD/YY) **Time** _____ (HH:MM) **Clinic Site** _____ (Site Where Exposure Occurred)

Location..... _____ (Location in Site Where Exposure Occurred) **Body Part** _____ (Body Part Exposed or Injured)

Examination ..... Date _____ (MM/DD/YY) Time _____ (HH:MM) **Clinic Site** _____ (Site Where Evaluation/Examination Occurred)

Primary Provider..... _____ (Name & Title of Primary Treatment Provider) **Consult Provider** _____ (Name & Title of HIV Team Provider or Nurse Case Manager (if different from Primary))

COMPLETE IF SHARPS PENETRATION INJURY

1. **When did the sharps injury occur?**
   - ☐-During use of the sharp
   - ☐-Between steps of a multi-step procedure
   - ☐-After use but before disposal of sharp
   - ☐-While placing sharp is disposal container
   - ☐-Sharp left in inappropriate place
   - ☐-Disassembling or rewinding sharp
   - ☐-Other
2. **During what procedure did the sharps injury occur?**
   - ☐-Drawing venous blood
   - ☐-Injection
   - ☐-Suturing
   - ☐-Starting IV/Heparin Lock
   - ☐-Fingerstick Collection
   - ☐-Changing dental burr
   - ☐-Other dental procedure
   - ☐-Other
3. **Identify the sharp involved in the sharps injury**

   Type _____

   Brand _____

   Model or Number _____
4. **Did the sharps device have engineered sharps injury protection?**
   ☐-Yes; ☐-No; ☐-Don't Know
5. **Was the protective mechanism of the sharps device activated?**
   ☐-Yes; ☐-No; ☐-Don't Know; ☐-Not Applicable
6. **With reference to the activation of the safety mechanism, when did the injury occur?**
   ☐-Before; ☐-During; ☐-After; ☐-Don't Know; ☐-Not Applicable
7. **If the sharps device did not have a safety mechanism, do you think that such a mechanism could have prevented your injury?**
   ☐-Yes; ☐-No; ☐-Don't Know
8. **Do you think that any other engineering, policy, protocol, training or instruction could have prevented your injury?**
   ☐-Yes; ☐-No; ☐-Don't Know

COMPLETE IF MUCOUS MEMBRANE OR NON-INTACT SKIN EXPOSURE

1. **What body parts were involved in the exposure incident?**
   - ☐-Ear(s)
   - ☐-Eye(s)
   - ☐-Face/Neck
   - ☐-Finger(s)
   - ☐-Foot (Feet)
   - ☐-Genitals
   - ☐-Hand(s)
   - ☐-Head
   - ☐-Leg(s)
   - ☐-Mouth
   - ☐-Nose
   - ☐-Trunk/Torso
   - ☐-Wrist(s)/Arm(s)
   - ☐-Other
2. **What type of event occurred to cause the exposure?**
   - ☐-Partial spill of lab specimen
   - ☐-Complete spill of lab specimen
   - ☐-Splash while carrying or moving lab specimen
   - ☐-Splash while transferring lab specimen to another container
   - ☐-Spurt of blood or other fluids during phlebotomy
   - ☐-Spurt of blood or other fluids during examination
   - ☐-Spurt of blood or other fluids during procedure
   - ☐-Patient spitting or coughing during examination
   - ☐-Failure of Personal Protective Equipment
   - ☐-Improper Placement/Use of Personal Protective Equipment
   - ☐-Other
3. **What Personal Protective Equipment (PPE) were you using at the time of the incident?**
   - ☐-Gloves
   - ☐-Face Mask (paper or cloth)
   - ☐-Face Shield
   - ☐-Scrub Top
   - ☐-Lab Coat
   - ☐-Other
4. **Do you think the use of any (or any other) PPE could have prevented this exposure?**
   ☐-Yes; ☐-No; ☐-Don't Know
5. **Do you think that any policy, protocol, training or instruction could have prevented this exposure?**
   ☐-Yes; ☐-No; ☐-Don't Know

Briefly describe the events immediately before, during and after the exposure incident, including your opinion of what caused the incident.

Employee Signature _____ *Date*_____

WORKER'S COMPENSATION CLAIM FORM (DWC1) & NOTICE OF POTENTIAL ELIGIBILITY

Esta forma esta disponible en Español. Por favor pregunte por la forma a su jefe de Oficina, El cordinador de enfermeras y enfeermeros, Administrador de Sitio, o Gerenten Corporativo de Riesgos.

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest back to your employer. Your employer will than complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, X-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.

The Primary Treatment Physician (PTP): is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after an employee files a claim form, the employer shall authorize the provisions of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you will receive temporary disability payments. These payments may change or stop when your doctor says you able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation and date of injury.

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

Supplemental Job Displacement Benefits (SJDB): If you do not return to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a non-transferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability. SJDB is a benefit for injuries occurring on or after 1/1/04.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Worker's Compensation, or you can hear recorded information and a list of local offices by calling **(800) 736-7401.** You may also go to the DWC web site at www.dir.ca.gov. Link to Workers' Compensation.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at www.californiaspecialist.org.

State of California
Department of Industrial Relations
Division of Workers' Compensation

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Esta forma esta disponible en Español. Por favor pregunte por la forma a su jefe de Oficina, El cordinador de enfermeras y enfeermeros, Administrador de Sitio, o Gerenten Corporativo de Riesgos.

EMPLOYEE: Complete the "**Employee**" section (below) and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt**" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent materials statement or material representation for the purposes of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

EMPLOYEE: Compete this section and see note above.

1. Name ..... _____ Today's Date: _____
2. Home Address ... _____
3. City ..... _____ State _____ Zip Code: _____
4. Date of Injury ..... _____ Time of Injury (AM/PM) _____
5. Address and description of where injury happened _____
   _____
6. Describe injury and part of body affected _____
   _____
7. Social Security Number ..... _____
8. Signature of Employee ..... _____

EMPLOYER: Complete this section and see note below.

9. Employer Name ..... **OPEN DOOR COMMUNITY HEALTH CENTERS**
10. Address ..... **670 NINTH STREET, SUITE 203, ARCATA, CALIFORNIA 95521**
11. Date employer first know of injury ..... _____
12. Date claim form was provided to employee ..... _____
13. Date employer received claim form ..... _____
14. Name and address of insurance carrier or adjusting agency ..... **NEW YORK MARINE & GEN INS COMPANY**
    CLAIMS ADM: ATHENS ADMINISTRATORS
15. Insurance Policy Number ..... **MEMBER NO: 0150441012**
16. Signature of Employer Representative ..... _____
17. Title _____ Telephone **707-826-8633 EXT 5139**

EMPLOYER: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee. **Signing this form is not an admission of liability.**

☐-Employer Copy ☐-Employee Copy ☐-Claims Administrator Copy ☐-Employee's Temporary Receipt