

Needle/Blood and Bodily Fluid Exposure

Date of Occurrence:	Time:	Day of Week:	Institution:
Source Individual Name:			
			<input type="checkbox"/> Male <input type="checkbox"/> Female
Diagnosis:			
Source Individual Consent signed for person exposed to receive information			<input type="checkbox"/> Yes <input type="checkbox"/> No
Source Individual Consent for blood test	Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Assistant Superintendent Notified.	Date:		
Narrative of Occurrence - if more space is needed, please attach additional pages.			
Name of person exposed:			<input type="checkbox"/> Male <input type="checkbox"/> Female
Counseling re: bloodborne pathogens?			
Consent for blood test:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	
Referred to:	Date:		