



Management of Percutaneous or Permucosal Exposure to Blood and Body Fluid/Laboratory Requisition

NOTE: If exposed and/or source person(s) choose non-nominal HIV testing, identify only by initials, sex, and date of birth. Refer to back of form for guidelines for obtaining informed consent.

Exposed Person Information [] NOMINAL HIV TESTING [] NON-NOMINAL HIV TESTING

Form fields for Exposed Person Information: SURNAME, GIVEN NAME, GENDER, PHN, DATE OF BIRTH, ADDRESS, HOME PHONE NUMBER, WORK PHONE NUMBER, DATE & TIME OF EXPOSURE, HAS THE EXPOSED PERSON PREVIOUSLY RECEIVED HEPATITIS B VACCINE?, SEROCONVERSION?, PREGNANT?, WAS THIS AN OCCUPATIONAL EXPOSURE?, IF YES, SPECIFY OCCUPATION, INDUSTRY, JOB ACTIVITY AT TIME OF ACCIDENT, EMPLOYER'S NAME, EMPLOYER'S PHONE NUMBER, DATE BLOOD COLLECTED.

Exposure Information

Form fields for Exposure Information: TYPE OF BODY FLUID, PLACE OF EXPOSURE, TYPE OF EXPOSURE, BODY SITE WHERE EXPOSURE OCCURRED, TYPE OF INSTRUMENT, IF PERCUTANEOUS EXPOSURE, WAS: BLOOD VISIBLE ON INSTRUMENT?, INSTRUMENT RECENTLY IN SOURCE'S ARTERY OR VEIN?

Source Person (source of blood or body fluid to which the exposed person was exposed) [] NOMINAL HIV TESTING [] NON-NOMINAL HIV TESTING

Form fields for Source Person: KNOWN?, GENDER, SURNAME, GIVEN NAME, DATE OF BIRTH, PHN, INFECTIOUS STATUS OF SOURCE, KNOWN MEMBER OF A HIGHER RISK GROUP FOR, DATE BLOOD COLLECTED.

Exposed Person Management - The Exposed Person Was Given:

Form fields for Exposed Person Management: HBIG, HEPATITIS B VACCINE, POST EXPOSURE TETANUS BOOSTER, TETANUS IMMUNE GLOBULIN, ANTIRETROVIRAL STARTER KIT, TIME STARTED.

Blood Testing (HBsAg, Anti-HBs, Anti-HBc, Anti-HCV, Anti-HIV are done routinely.)

LAB RESULTS TO BE FAXED/PHONED TO: SOURCE PERSON, EXPOSED PERSON. Fields for SOURCE PERSON'S FOLLOW-UP PHYSICIAN, EXPOSED PERSON'S FOLLOW-UP PHYSICIAN, WORKSITE OCC HEALTH, PHONE #, FAX #, NAME, MSC #.

It is the responsibility of the requesting health care provider to obtain consent from the exposed and/or source person for all laboratory testing as indicated below and for release of information on this form to public health authorities, WCB (if exposure is occupational), and those people listed above. Refer to back of form for guidelines for obtaining informed consent.

NAME OF HEALTH CARE PROVIDER COMPLETING ABOVE SECTION OF FORM AND REQUESTING BLOODWORK (PRINT), DATE (YYYY / MM / DD), WCB PURPOSES ONLY, MSC #, SIGNATURE OF PHYSICIAN, WCB BILLING CODE # 19909.

FOR LABORATORY USE ONLY Put a line through the tests that are not to be done

Form for Laboratory Use Only: DATE RECEIVED AT LABORATORY, TIME RECEIVED, RECEIVED BY, SAMPLE, TESTS (BY EIA), HBsAg, ANTI-HBs, ANTI-HBc, ANTI-HCV, ANTI-HIV, SOURCE PERSON LAB ID ONLY, EXPOSED PERSON'S NAME, EXPOSED PERSON'S LAB ID, TIME, DATE (YYYY / MM / DD), INITIALS, REVIEWED BY, DATE (YYYY / MM / DD).

RESULTS FAXED / PHONED TO [] EXPOSED PERSON'S PHYSICIAN [] EXPOSED PERSON'S WORKSITE OCCUPATIONAL HEALTH [] SOURCE PERSON'S PHYSICIAN



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Exposed Person Information [] NOMINAL HIV TESTING [] NON-NOMINAL HIV TESTING

Form section for Exposed Person Information including fields for SURNAME, GIVEN NAME, GENDER, PHN, DATE OF BIRTH, ADDRESS, HOME PHONE NUMBER, WORK PHONE NUMBER, DATE & TIME OF EXPOSURE, HAS THE EXPOSED PERSON PREVIOUSLY RECEIVED HEPATITIS B VACCINE?, SEROCONVERSION?, PREGNANT?, WAS THIS AN OCCUPATIONAL EXPOSURE?, IF YES, SPECIFY OCCUPATION, INDUSTRY, JOB ACTIVITY AT TIME OF ACCIDENT, EMPLOYER'S NAME, EMPLOYER'S PHONE NUMBER, DATE BLOOD COLLECTED.

Exposure Information

Form section for Exposure Information including fields for TYPE OF BODY FLUID, PLACE OF EXPOSURE, TYPE OF EXPOSURE, BODY SITE WHERE EXPOSURE OCCURRED, TYPE OF INSTRUMENT, and IF PERCUTANEOUS EXPOSURE, WAS: BLOOD VISIBLE ON INSTRUMENT?, INSTRUMENT RECENTLY IN SOURCE'S ARTERY OR VEIN?.

Source Person (source of blood or body fluid to which the exposed person was exposed) [] NOMINAL HIV TESTING [] NON-NOMINAL HIV TESTING

Form section for Source Person information including fields for KNOWN?, GENDER, SURNAME, GIVEN NAME, DATE OF BIRTH, PHN, INFECTIOUS STATUS OF SOURCE, KNOWN MEMBER OF A HIGHER RISK GROUP FOR, and DATE BLOOD COLLECTED.

Exposed Person Management - The Exposed Person Was Given:

Form section for Exposed Person Management including checkboxes for HBIG, HEPATITIS B VACCINE, POST EXPOSURE TETANUS BOOSTER, TETANUS IMMUNE GLOBULIN, and ANTIRETROVIRAL STARTER KIT, along with TIME STARTED.

Blood Testing (HBsAg, Anti-HBs, Anti-HBc, Anti-HCV, Anti-HIV are done routinely.)

LAB RESULTS TO BE FAXED/PHONED TO:

Table for LAB RESULTS TO BE FAXED/PHONED TO with columns for SOURCE PERSON and EXPOSED PERSON, including fields for SOURCE PERSON'S FOLLOW-UP PHYSICIAN, EXPOSED PERSON'S FOLLOW-UP PHYSICIAN, WORKSITE OCC HEALTH, PHONE #, FAX #, NAME, and MSC #.

It is the responsibility of the requesting health care provider to obtain consent from the exposed and/or source person for all laboratory testing as indicated below and for release of information on this form to public health authorities, WCB (if exposure is occupational), and those people listed above. Refer to back of form for guidelines for obtaining informed consent.

Form section for WCB PURPOSES ONLY including fields for NAME OF HEALTH CARE PROVIDER, DATE, MSC #, SIGNATURE OF PHYSICIAN, and WCB BILLING CODE # 19909.

FOR LABORATORY USE ONLY

Put a line through the tests that are not to be done

Form section for LABORATORY USE ONLY including fields for DATE RECEIVED AT LABORATORY, TIME RECEIVED, RECEIVED BY, SAMPLE, TESTS (BY EIA), HBsAg, ANTI-HBs, ANTI-HBc, ANTI-HCV, ANTI-HIV, SOURCE PERSON LAB ID ONLY, EXPOSED PERSON'S NAME, EXPOSED PERSON'S LAB ID, TIME, DATE, INITIALS, REVIEWED BY, and RESULTS FAXED / PHONED TO.



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Exposed Person Information [] NOMINAL HIV TESTING [] NON-NOMINAL HIV TESTING

Form section for Exposed Person Information including fields for SURNAME, GIVEN NAME, GENDER, PHN, DATE OF BIRTH, ADDRESS, HOME PHONE NUMBER, WORK PHONE NUMBER, DATE & TIME OF EXPOSURE, HAS THE EXPOSED PERSON PREVIOUSLY RECEIVED HEPATITIS B VACCINE?, SEROCONVERSION?, PREGNANT?, WAS THIS AN OCCUPATIONAL EXPOSURE?, IF YES, SPECIFY OCCUPATION, INDUSTRY, JOB ACTIVITY AT TIME OF ACCIDENT, EMPLOYER'S NAME, EMPLOYER'S PHONE NUMBER, DATE BLOOD COLLECTED.

Exposure Information

Form section for Exposure Information including fields for TYPE OF BODY FLUID, PLACE OF EXPOSURE, TYPE OF EXPOSURE, BODY SITE WHERE EXPOSURE OCCURRED, TYPE OF INSTRUMENT, and IF PERCUTANEOUS EXPOSURE, WAS: BLOOD VISIBLE ON INSTRUMENT?, INSTRUMENT RECENTLY IN SOURCE'S ARTERY OR VEIN?.

Source Person (source of blood or body fluid to which the exposed person was exposed) [] NOMINAL HIV TESTING [] NON-NOMINAL HIV TESTING

Form section for Source Person including fields for INFECTIOUS STATUS OF SOURCE, KNOWN MEMBER OF A HIGHER RISK GROUP FOR, and DATE BLOOD COLLECTED.

Exposed Person Management - The Exposed Person Was Given:

Form section for Exposed Person Management including fields for HBIG, HEPATITIS B VACCINE, POST EXPOSURE TETANUS BOOSTER, TETANUS IMMUNE GLOBULIN, and ANTIRETROVIRAL STARTER KIT.

Blood Testing (HBsAg, Anti-HBs, Anti-HBc, Anti-HCV, Anti-HIV are done routinely.)

Form section for Blood Testing including LAB RESULTS TO BE FAXED/PHONED TO: SOURCE PERSON and EXPOSED PERSON.

It is the responsibility of the requesting health care provider to obtain consent from the exposed and/or source person for all laboratory testing as indicated below and for release of information on this form to public health authorities, WCB (if exposure is occupational), and those people listed above. Refer to back of form for guidelines for obtaining informed consent.

Form section for Blood Testing including NAME OF HEALTH CARE PROVIDER COMPLETING ABOVE SECTION OF FORM AND REQUESTING BLOODWORK (PRINT), DATE, WCB PURPOSES ONLY, SIGNATURE OF PHYSICIAN, and WCB BILLING CODE.

FOR LABORATORY USE ONLY Put a line through the tests that are not to be done

Form section for Laboratory Use Only including fields for DATE RECEIVED AT LABORATORY, TIME RECEIVED, RECEIVED BY, SAMPLE, TESTS (BY EIA), HBsAg, ANTI-HBs, ANTI-HBc, ANTI-HCV, ANTI-HIV, SOURCE PERSON LAB ID ONLY, EXPOSED PERSON'S NAME, EXPOSED PERSON'S LAB ID, TIME, DATE, INITIALS, REVIEWED BY, DATE.

Form section for Laboratory Use Only including RESULTS FAXED / PHONED TO: [] EXPOSED PERSON'S PHYSICIAN [] EXPOSED PERSON'S WORKSITE OCCUPATIONAL HEALTH [] SOURCE PERSON'S PHYSICIAN



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Exposed Person Information [] NOMINAL HIV TESTING [] NON-NOMINAL HIV TESTING

Form fields for Exposed Person Information including SURNAME, GIVEN NAME, ADDRESS, DATE & TIME OF EXPOSURE, HAS THE EXPOSED PERSON PREVIOUSLY RECEIVED HEPATITIS B VACCINE?, SEROCONVERSION?, PREGNANT?, EMPLOYER'S NAME, EMPLOYER'S PHONE NUMBER, DATE BLOOD COLLECTED.

Exposure Information

Form fields for Exposure Information including TYPE OF BODY FLUID, PLACE OF EXPOSURE, TYPE OF EXPOSURE, BODY SITE WHERE EXPOSURE OCCURRED, TYPE OF INSTRUMENT, IF PERCUTANEOUS EXPOSURE, WAS: BLOOD VISIBLE ON INSTRUMENT?, INSTRUMENT RECENTLY IN SOURCE'S ARTERY OR VEIN?

Source Person (source of blood or body fluid to which the exposed person was exposed) [] NOMINAL HIV TESTING [] NON-NOMINAL HIV TESTING

Form fields for Source Person including INFECTIOUS STATUS OF SOURCE (HIV+, HBsAg+, HCV+), KNOWN MEMBER OF A HIGHER RISK GROUP FOR: (HIV, HBV, HCV), DATE BLOOD COLLECTED.

Exposed Person Management - The Exposed Person Was Given:

Form fields for Exposed Person Management including HBIG, HEPATITIS B VACCINE, POST EXPOSURE TETANUS BOOSTER, TETANUS IMMUNE GLOBULIN, ANTIRETROVIRAL STARTER KIT, TIME STARTED.

Blood Testing (HBsAg, Anti-HBs, Anti-HBc, Anti-HCV, Anti-HIV are done routinely.)

Form fields for Blood Testing including LAB RESULTS TO BE FAXED/PHONED TO: SOURCE PERSON, EXPOSED PERSON, NAME, PHONE #, FAX #, WORKSITE, MSC #.

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Form fields for Blood Testing including NAME OF HEALTH CARE PROVIDER COMPLETING ABOVE SECTION OF FORM AND REQUESTING BLOODWORK (PRINT), DATE (YYYY / MM / DD), WCB PURPOSES ONLY, MSC #, SIGNATURE OF PHYSICIAN, WCB BILLING CODE # 19909.

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Form fields for Laboratory Use Only including DATE RECEIVED AT LABORATORY, TIME RECEIVED, RECEIVED BY, SAMPLE, TESTS (BY EIA), HBsAg, ANTI-HBs, ANTI-HBc, ANTI-HCV, ANTI-HIV, SOURCE PERSON LAB ID ONLY, EXPOSED PERSON'S NAME, EXPOSED PERSON'S LAB ID, TIME, DATE (YYYY / MM / DD), INITIALS, REVIEWED BY, DATE (YYYY / MM / DD).

Form fields for Laboratory Use Only including RESULTS FAXED / PHONED TO: [] EXPOSED PERSON'S PHYSICIAN [] EXPOSED PERSON'S WORKSITE OCCUPATIONAL HEALTH [] SOURCE PERSON'S PHYSICIAN