## REQUEST FOR SOURCE INDIVIDUAL EVALUATION

Dear **(Healthcare Provider)**:

Recently, a school district employee was involved in an incident that may have resulted in exposure to a Bloodborne Pathogen from another (source) individual.

I am asking you to perform an evaluation of the source individual. Given the circumstances surrounding this event, please determine whether our exposed school district employee is at risk for infection and/or requires medical follow-up.

Attached is a **“Documentation and Identification of Source Individual”**form which was initiated by the exposed worker. Please complete the **source individual section** and communicate the findings to the designated medical provider.

The evaluation form has been developed to provide confidentiality assurances for the patient and the exposed worker concerning the nature of the exposure. Any communication regarding the findings is to be handled at the medical provider level.

We understand that information relative to human immunodeficiency virus (HIV) and AIDS has specific protections under the law and cannot be disclosed or released without the written consent of the persons who receive such information to hold it confidential.

Thank you for your assistance in this very important matter.

Sincerely,

***L***

## DOCUMENTATION AND IDENTIFICATION OF SOURCE INDIVIDUAL

**CONFIDENTIAL**

Name of Exposed Employee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and phone number of medical provider who should be contacted:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INCIDENT INFORMATION**

Date:

Name or medical record number of the individual who is the source of the exposure:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Record #:\_\_\_\_\_\_\_\_\_\_\_\_\_

**NATURE OF THE INCIDENT**

🞎 Contaminated Needle stick Injury

🞎 Blood or Body fluid Splash onto Mucous Membrane or Non-Intact Skin

🞎 Other:

**REPORT OF SOURCE INDIVIDUAL EVALUATION**

Chart Reviewed By Date

Source Individual Unknown – Researched By Date

Testing of Source Individual’s Blood:  **Consent**  🞎 Obtained 🞎 Refused

**CHECK ONE:**

🞎 Identification of source individual infeasible or prohibited by state or local law. State why if infeasible:

🞎 Evaluation of the source individual reflected no known exposure to Bloodborne Pathogen.

🞎 Evaluation of the source individual reflected possible exposure to Bloodborne Pathogen and medical follow-up is recommended.

Person completing report: Date:

**NOTES:**

* **Report the results of the source individual’s blood tests to the medical provider named above who will inform the exposed employee. Do not report blood test findings to the employer.**
* **HIV-related information cannot be released without the written consent of the source individual.**

## EMPLOYEE EXPOSURE FOLLOW-UP RECORD

**CONFIDENTIAL**

Employee’s Name: Job Title:

Occurrence Date: Reported Date:

Occurrence Time:

**SOURCE INDIVIDUAL FOLLOW-UP:**

Request made to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Time

**EMPLOYEE FOLLOW-UP:**

Employee’s Health File Reviewed By

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information given on source individual’s blood test results: 🞎 Yes 🞎 Not Obtained

**Referred to Healthcare Professional with Required Information:**

Name of healthcare professional

By Whom Date

**Blood Sampling/Testing Offered:**

By Whom Date

**Vaccination Offered/Recommended:**

By Whom Date

**Counseling Offered:**

By Whom Date

**Employee Advised of Need for Further Evaluation of Medical Condition:**

By Whom Date

**HEALTHCARE PROFESSIONALS WRITTEN OPINION**

(To be completed by the healthcare provider and returned to the school district)

Name of Medical Care Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examining Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: Chart #

Examined on: Date Time

**Hepatitis B Vaccination Recommended:**

Yes \_\_\_\_\_ Vaccination Administered on: Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No \_\_\_\_\_\_ Employee was previously vaccinated on: Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Employee has been advised of the results of the evaluation. 🞎 Yes 🞎 No

The Employee has been advised of any medical conditions that may result from exposure to blood and if further evaluation or treatment is needed. 🞎 Yes 🞎 No

**The Healthcare Provider should return this form directly to the school district:**

San Juan Island School District

P.O. Box 458

Friday Harbor, WA 98250

Attention: **Director of Human Resources**

Refer questions to the San Juan Island School District #149, Director of Human Resources @ (360) 370-7904.