INSTRUCTIONS
Oklahoma State Department of Health
Communicable Disease Risk Exposure Report

This report form was developed to initiate a system of notification for risk exposures occurring outside of a health care facility to health care workers, emergency responders, and funeral workers as specified by the Oklahoma State Department of Health OAC 310:555. This report and all information entered on it are to be held in strictest confidence to conform with 63 O.S. Supp. 2001, Section 1-502.1 et. Seq.

Note: For questions regarding the handling of ODH Form 207, call 405/426-8400.

PART I: Exposed Worker Section

Questions 1-13 are to be completed by the exposed worker, immediately following the injury.

11: Describe exposure in detail. Include information regarding type of exposure, body part affected, type of body fluid involved, duration of exposure, etc.

13: List the facility where the source patient was taken. This will be the facility that is responsible for testing the source patient.

Questions 14-19 are to be completed by the Employer's Designee, immediately following the injury.

Questions 20-22 are to be completed by a Licensed Health Care Professional (MD, DO, RN, PA).

Routing:

A. If the Licensed Health Care Professional determines that the exposure does not have the potential for transmission of a communicable disease, the form should be returned to the Employer's Designee.
B. If the exposure does have the potential for transmission of a communicable disease, the Yellow copy should be mailed ***immediately*** to the OSDH Sexual Health and Harm Reduction Service (use gray, self-addressed, metered envelope).

The ***Pink*** copy, a gray metered envelop and instruction page are to be delivered ***immediately*** to the designated person (usually the Infection Control Practitioner) at the health care facility to which the source patient was transported; to the attending physician, if the source patient was being cared for outside of a health care facility; to the health care provider who last had responsibility for the deceased source patient; or to the medical examiner.

PART II: Source Patient Health Care Provider Section

Questions 23-38 are to be completed by the Health Care Provider who is responsible for testing the source patient.

32. Rapid HIV testing has become a valuable tool used to quickly determine the need for initiation and/or continuation of PEP meds for the exposed person. When a rapid HIV test is performed on the source patient, communication of these results should not be delayed. The results should be ***immediately*** communicated to the physician/provider who is providing post/exposure counseling and follow up and is listed on page 1. q. 17-19.

    Please note that as other source results become available, these should be released to the Provider listed on pate 1, q. 17-19.

Routing: The Health Care Provider should complete Part II and mail the completed pink form to the OSDH Sexual Health and Harm Reduction Service immediately using the gray, self-addressed, metered envelope.

Communicable Disease Risk Exposure Report

The filing of this report initiates a system of notification for risk exposures occurring outside of a health care facility to health care workers, emergency responders and funeral workers as specified by the Oklahoma State Department of Health OAC 310:555. This report and all information entered on it are to be held in strictest confidence in conformance with 63 O.S. Supp. 2001, Section 1-502.1 et. Seq.

Part 1: Exposed Worker Section (Please Print)

1. Employee Name: _____ 2. Birth date: ____/____/____
(Last) (First) (MI) (Mo/Day/Yr.)

3. Home Telephone (___) _____ 4. Professional/Job Title: _____

5. Employer/Company Name: _____

6. Work Address/Telephone: _____
(Street) (City) (Zip) Telephone

7. Number of hepatitis B vaccinations previously received: ☐ **None;** ☐ **1:** ☐ **2:** ☐ **3**

8. Date of Exposure: (Mo/Day/Yr.) ___/___/___ 9. Time of Exposure: _____ AM or PM (Circle One)

10. Supervisor's Name/Telephone: _____ (___) _____
Telephone

11. Description of Exposure: _____

_____

12. Source Patient Name: _____
(Last) (First) (M.I.)

13. Location of Source Patient (include name of facility, address and phone number): _____

_____

To be completed by Employers' Designee:

I have reviewed the circumstances and management of this incident and verify that the appropriate follow-up (according to our agency Exposure Control Plan) is being attempted in order to identify or prevent the transmission of communicable diseases to which the employee may be at risk as a result of this exposure.

14. _____ 15. _____ 16. ____/____/____
Name & Title (Print) Signature Mo. Day Yr.

Post-exposure counseling and follow-up will be provided to this employee by:

17. _____ 18. _____ 19. _____
Provider's Name Provider's Telephone Number Provider's Fax Number

To Be Completed by a Licensed Health Care Professional (MD, DO, RN, PA)

In my professional judgment, this ☐ **was** ☐ **was not** a mucosal, percutaneous or respiratory exposure that has the potential for transmission of a communicable disease, such as hepatitis B, hepatitis C, HIV, TB or meningococcus.

20. _____ 21. _____ 22. ____/____/____
Name & Title (Print) Signature Mo. Day Yr.

For consultation regarding exposures and PEP meds: PEP Hotline: 1-888-448-4911

Note: If this exposure does not warrant medical follow-up, please return the form to the Employer's Designee and indicate to that individual why no follow-up is required.

If this is an exposure that warrants medical follow-up, the employer shall handle the report accordingly.

A. ***Yellow*** copy to be mailed ***Immediately*** to the OSDH Sexual Health and Harm Reduction Service (use gray, self-addressed, metered envelope) at 123 Robert S Kerr Ave, Suite 1702, Oklahoma City, OK 73102.

B. ***Pink*** copy, a gray metered envelop and instruction page to be delivered ***Immediately*** to the designated person (usually the Infection Control Practitioner) at the location of the source patient.

Part II: Source Patient Health Care Provider Section (*Please Print*)

23. Date and time 207 Form received: _____/_____/_____ Time: _____ AM or PM (Circle one)
(Mo/Day/Yr.)

24. Person completing Part II: _____
(Last) (First) (Title)

25. Institution (name): _____ Business Phone: _____

Source Patient Information

26. Birth Date: (Mo./Day/Yr.) _____ 27. Sex: ☐ **Male** ☐ **Female**

28. Primary Diagnosis: _____

29. Was the patient found to have any potentially communicable disease(s), such as hepatitis B, hepatitis C, HIV, TB, meningococcal disease, or others? ☐ **Yes** ☐ **No**

30. If yes, specify: _____

31. Does the source patient have any clinical evidence of AIDS or symptoms of HIV infection or acute retroviral syndrome?
☐ **Yes** ☐ **No**

Source Patient Test Results

32. Rapid HIV test: ☐ **Positive** ☐ **Negative** ☐ **Invalid** ☐ **Not Done** Test Date: _____
(Mo/Day/Yr.)

Note: IMMEDIATELY report Rapid HIV results by phone or fax to the Provider listed on page 1, q. 17-19. As other test results become available, these are also to be released to the Provider listed on page 1, q. 17-19.

33. HBsAg: ☐ **Positive;** ☐ **Negative** ☐ **Not done** Test Date: _____
(Mo/Day/Yr.)

34. anti-HCV: ☐ **Positive;** ☐ **Negative** ☐ **Not done** Test Date: _____
(Mo/Day/Yr.)

35. HIV : ☐ **Positive;** ☐ **Negative** ☐ **Not done** Test Date: _____
☐ **Indeterminate**
(Mo/Day/Yr.)

36. Other: Name of Test: _____ Test Result: _____ Test Date: _____
(Mo/Day/Yr.)

Note: Source results may be released to the source patient; the exposed person's physician/provider or ODH per OAC 310:555.

37. Date results released to Provider: _____ 38. Date mailed to OSDH: _____
(Mo/Day/Yr.) (Mo/Day/Yr.)

When Part II is completed, mail immediately to the OSDH Sexual Health and Harm Reduction Service using the gray self-addressed, metered envelope.

Part III: OSDH Section (*Please Print*)

Date Report Received: _____ Person Completing Part III. _____
(Mo/Day/Yr.) (Last) (First)

OSDH Division: _____

Follow-Up Action: _____

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