

<b>CITY OF PHILADELPHIA</b> <i>Blood Borne Pathogen</i> <b>EXPOSURE REPORT FORM</b>		1. DEPT./DIVISION	2. UNIT	3. PAYROLL NO.
		4. NAME (Last) (First) (M.I.)		
<b>PART I: EMPLOYEE INFORMATION</b>				
5. JOB TITLE				
6. HEPATITIS B VACCINE: <input type="checkbox"/> 1- SERIES COMPLETED (DATE: ___ / ___ / _____) <input type="checkbox"/> 2 - IN PROGRESS (next shot date: ___ / ___ / _____) <input type="checkbox"/> 3- NO				
7. IMMEDIATE SUPERVISOR			8. IMMEDIATE SUPERVISOR CONTACT NUMBER (S) ( ) ( )	
9. WORK ASSIGNMENT: PLEASE CHECK THE <b>MOST APPROPRIATE</b> CATEGORY				
<input type="checkbox"/> 1. ROUTINE / NORMAL <input type="checkbox"/> 3. NON-ROUTINE / SPECIAL ASSIGNMENT <input type="checkbox"/> 2. EMERGENCY RESPONSE ASSIGNMENT <input type="checkbox"/> 4. OTHER _____				
<b>SOURCE PATIENT INFORMATION</b>				
10. NAME (IF KNOWN) (LAST) (FIRST) (M.I.) <input type="checkbox"/> UNKNOWN				
11. EMPLOYEE RELATION <input type="checkbox"/> 1- CO-WORKER <input type="checkbox"/> 3-PUBLIC / STRANGER <input type="checkbox"/> 5- UNKNOWN <input type="checkbox"/> 2- CLIENT <input type="checkbox"/> 4-DECEASED <input type="checkbox"/> 6- OTHER _____				
12. CASE HISTORY INFORMATION OF SOURCE (If Applicable, provide as much information about the source as possible, including known health status, address or phone number)				
<b>PART II: DESCRIPTION OF EXPOSURE</b> (Use additional sheets if necessary)				
13. EXPOSURE TYPE				
<input type="checkbox"/> 1-HANDLING BLOOD/OPIM SPECIMENS <input type="checkbox"/> 4 - CLEANING BLOOD/OPIM <input type="checkbox"/> 7 - NEEDLESTICK (TYPE) _____ <input type="checkbox"/> 2- PROVIDING FIRST AID / CPR <input type="checkbox"/> 5 - SPLASH OF BLOOD/ OPIM <input type="checkbox"/> 8 - CONTAMINATED SHARP OBJECT (TYPE) _____ <input type="checkbox"/> 3 - HANDLING BIO-HAZARD WASTE <input type="checkbox"/> 6 - PICK-UP OF HOUSEHOLD TRASH <input type="checkbox"/> 9 - OTHER (SPECIFY) _____				
14. BODILY FLUID TYPE <input type="checkbox"/> 1 - HUMAN BLOOD <input type="checkbox"/> 4- SALIVA ( with visible blood: Yes / No ) <input type="checkbox"/> 7 - VOMITUS ( with visible blood: Yes / No ) <input type="checkbox"/> 2 - SEMEN <input type="checkbox"/> 5 -FECES ( with visible blood: Yes / No ) <input type="checkbox"/> 3 - VAGINAL SECRECTIONS <input type="checkbox"/> 6 - URINE ( with visible blood: Yes / No )				
15. TREATMENT SITE SENT TO: <input type="checkbox"/> 1- ER <input type="checkbox"/> 2 - MEDICAL SITE _____			16. POST EXPOSURE PROPHYLAXIS (PEP) COUNSELING ; <input type="checkbox"/> 1- YES <input type="checkbox"/> 2- NO MEDICAL SITE: _____ DATE: _____ TIME: _____	
17. DESCRIBE INCIDENT IN DETAIL: <i>WHAT, HOW, WHERE, &amp; WHEN</i> ; with DETAILS OF TASKS BEING PERFORMED and INSTRUMENT, FLUID OR MATERIAL INVOLVED (Use back of page if necessary).				
18. AMOUNT OF BLOOD/BODILY FLUID, EXPOSURE SITE & DURATION OF CONTACT (Estimate volume of material, contact site [same as #31 on COPA II] & length of time of contact)				
19. SEVERITY OF EXPOSURE (i.e. Percutaneous Exposure - depth & size of injury site; Skin Exposure - condition of skin [i.e. chapped, abraded, or intact]; Mucous-membrane - large mixing)				
<b>PART III: COPA II FORM</b>				
20. COPA II FORM COMPLETED (You must also complete): <input type="checkbox"/> 1- YES (DATE: ___ / ___ / ___ ) <input type="checkbox"/> 2 - NO				
<b>PART IV: SIGNATURE</b>				
21. COMPLETED BY: _____			DATE: ___ / ___ / 20____	