

# Inyo County Health & Human Services

## Post Exposure Check List

Name of exposed: \_\_\_\_\_ Date and Time of exposure: \_\_\_\_\_  
Name of supervisor \_\_\_\_\_ Date/name of Risk Manager/HHS notified \_\_\_\_\_  
Location of Exposure incident: \_\_\_\_\_ Incident Report Completed: \_\_\_\_\_  
Type of Exposure: \_\_\_\_\_  
Employee Action Taken: \_\_\_\_\_  
Chief Medical Officer/Designee Recommendation: \_\_\_\_\_

### Follow-up Check List For Exposed Employee

#### **Baseline Laboratory/workup:**

**HIV Pre-Counseling** \_\_\_\_\_ **Hepatitis B & C Information /counseling** \_\_\_\_\_  
**HIV Baseline Test Date** \_\_\_\_\_ **Date results given** \_\_\_\_\_  
**Hepatitis B/C Baseline Test Date:** \_\_\_\_\_ **anti-HBs** \_\_\_\_\_ \*if vaccinated/response unknown  
\_\_\_\_\_ **anti-HCV** \_\_\_\_\_ **ALT** \_\_\_\_\_ \* if source HCV positive  
**Date results given:** \_\_\_\_\_ \*no baseline if negative source

#### **Follow-up Labs:**

**HIV 3 Month Test Date** \_\_\_\_\_ **Date results given** \_\_\_\_\_  
**6 Month Test Date** \_\_\_\_\_ **Date results given** \_\_\_\_\_  
\*If source HIV positive:  
**6 Weeks Test Date** \_\_\_\_\_ **Date results given** \_\_\_\_\_  
**12 Months Test Date** \_\_\_\_\_ **Date results given** \_\_\_\_\_ (Only if HCP becomes infected with HCV)

**HCV 4-6 weeks Date:** \_\_\_\_\_ **HCV- RNA** \_\_\_\_\_ \* if known Hep C source or high risk source  
**4-6 months Date:** \_\_\_\_\_ **anti-HCV** \_\_\_\_\_ **ALT** \_\_\_\_\_

**HBV 1-2 months after last dose of vaccine Date:** \_\_\_\_\_ **anti-HBs**  
\*If HBIG given in last 3-4 months do not do antibody titer

#### **Treatment Information:**

**HIV Prophylaxis ordered:** \_\_\_\_\_ **Date started:** \_\_\_\_\_ **72 hour FU to disclose source status** \_\_\_\_\_  
**Therapy ordered:** \_\_\_\_\_

**Sign Intent to Avoid Pregnancy:** \_\_\_\_\_

**Hepatitis B vaccine :** #1 in series **Date given:** \_\_\_\_\_ **Booster doses(s)** \_\_\_\_\_  
#2 in series: 1 month **Date given:** \_\_\_\_\_  
#3 in series: 6 month **Date given:** \_\_\_\_\_

**HBIG #1 ordered** \_\_\_\_\_ **Date given:** \_\_\_\_\_ **HBIG #2 ordered** \_\_\_\_\_ **Date given:** \_\_\_\_\_  
(4 week interval)

**Referral to private physician given:** \_\_\_\_\_

**Signatures:** Chief Medical Officer/Designee \_\_\_\_\_ Date: \_\_\_\_\_  
Employee \_\_\_\_\_ Date: \_\_\_\_\_

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*This page to be kept with original file. Do not distribute to exposed employee.*

**Source Person Information**

Voluntary Consent to be tested: \_\_\_\_\_ Date: \_\_\_\_\_ or  
Refused Testing: \_\_\_\_\_ Date: \_\_\_\_\_ District Attorney's Office Notified \_\_\_\_\_

Pre Test HIV Counseling: \_\_\_\_\_ HIV Baseline: Date tested \_\_\_\_\_ (Rapid test if possible)  
Post Test HIV Counseling & Disclosure: Date \_\_\_\_\_

Hepatitis Screening: HbsAg \_\_\_\_\_  
anti-HCV EIA/RIBA \_\_\_\_\_ \*if positive HCV RNA \_\_\_\_\_

\*\*If source is infant: Less than 15 months of age test must be done on mother  
If infant has had blood transfusion, test baby also

\*\*Direct virus assays are not recommended

Source: US Public Health Guidelines 2001  
MMWR 1/24/03 vol.52

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