

EXPOSURE TO INFECTIOUS AGENT REPORT FORM

(Please return completed form to EHSS at 0423, email to sowen@vt.edu, or fax to 1-866-460-0028)

EXPOSED EMPLOYEE INFORMATION	
Name:	Hokie ID No.:
Job Title:	Home Department:
Phone Numbers	Work: Home:
Brief Summary of Job Duties: _____ _____ _____	
HBV Vaccination Series? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates Received:
Previous Titer Analysis Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: Results:
EXPOSURE INCIDENT INFORMATION	
Date of Incident: ____/____/____	Campus Location:
Time of Incident: ____:____ am pm	Infectious Agent (if known):
Route of Exposure (circle): <input type="checkbox"/> Non-Intact Skin <input type="checkbox"/> Mucous Membrane <input type="checkbox"/> Puncture	
Circumstances of Exposure: _____ _____ _____ _____ _____ _____	
SOURCE INDIVIDUAL INFORMATION (IF APPLICABLE)	
Name (if known):	Hokie ID/SSN No.:
Consent For Testing Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HBV Status:	HIV Status:

FOLLOW-UP

Physician's Visit Yes No

Physician Name: _____

Phone Number: _____

Address: _____

Please Check All That Apply		Comments
Baseline Blood Collection	<input type="checkbox"/>	
HIV Serological Status	<input type="checkbox"/>	
HBV Post-Exposure Series	<input type="checkbox"/>	
HBV Immune Globulin	<input type="checkbox"/>	
HBV Titer	<input type="checkbox"/>	
Counseling	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	

If this is a Laboratory Exposure, please describe any modifications that have been made to the organism you are working with:
