

**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 405/271-4636.

**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 HIV/STD 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 page 1, q. 17-19.

Routing: The Health Care Provider should complete Part II and mail the completed pink form to the OSDH HIV/STD 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 HIV/STD Service (use gray, self-addressed, metered envelope) at 1000 NE 10<sup>th</sup> St., OKC, OK 73110.  
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?

**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 release to Provider: \_\_\_\_\_ 38. Date mailed to OSDH: \_\_\_\_\_  
(Mo/Day/Yr.) (Mo/Day/Yr.)

**When Part II is completed, mail immediately to the OSDH HIV/STD 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: \_\_\_\_\_