IDAHO DEPARTMENT OF HEALTH AND WELFARE
SIGNIFICANT EXPOSURE INFORMATION REQUEST

This form is to be used ONLY for potential exposure to AIDS, HIV, and/or Hepatitis B.

(Completed and signed by person providing emergency or medical services)
Must be received within 14 days of incident

Please Print: (Home)_____

Name_____ Phone (Work)_____

Home Address_____
Street City State Zip Code

Occupation_____

Emergency Service Affiliation_____

Emergency Service Report Number_____

Incident: Date_____ Time_____ A.M./P.M. Place_____ Type_____

Have you received hepatitis B vaccine? Yes___ No___ (e.g., auto accident, etc.)

Exposure Description: (Check all applicable responses.)

- ☐ Blood or body fluids into natural body openings (nose, mouth, eye)
- ☐ Blood or body fluids into cut or wound
- ☐ Needle stick with contaminated needle
- ☐ Mouth-to-mouth resuscitation
- ☐ Resuscitation using device without backflow guard

Please describe how you think you were exposed to blood or body fluid of the person(s) you attended to:_____

_____

_____

_____

Source of Exposure:

Patient's name_____ Birthdate: __/__/___ Sex: M_____ F_____

Health care facility receiving patient_____

Additional Information:

Describe any action taken in response to the exposure to remove the contamination (e.g., hand washing):_____

_____

_____

_____

What protective measures were being taken at the time of exposure (e.g., wearing gloves, goggles):_____

_____

I hereby consent to the release of this medical record to the Idaho Department of Health and Welfare and the local district health department and agree to hold in confidence information regarding this report.

Signature_____ Date_____

Please mail in envelope stamped "Confidential" to:
Bureau of Communicable Disease Prevention
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036
Fax: 208-332-7307

DHW USE ONLY

Request approved for processing: No ☐ Yes ☐

_____
Signature of DHW Official

_____
Date

Revised: 12/19/2012