**OSHA COPY**

**DATE**

**EMPLOYER’S SIGNATURE**

Combination claim arising from the above incident

Permission is given to the Employee’s Health Service or Medical Records for release of those portions of my medical record pertinent to any worker.

**DATE**

**EMPLOYER’S SIGNATURE**

I refuse to accept Employee’s Medical

Disclaimer: 

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<th>Disposition</th>
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**PHYSICIAN’S SIGNATURE**

Medications:

- As directed
- Other (Specify)

**EMPLOYER’S SIGNATURE**

Employee Position

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**EMPLOYER’S SIGNATURE**

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PRIVILEGED AND CONFIDENTIAL BLOOD/BODY FLUID EXPOSURE WORKSHEET
TO BE COMPLETED BY SUPERVISOR OF AREA

Email to: # EHS MSH Providers

Date: __________ Location: ______________

Name of EXPOSED (Employee/Student/Visitor/Patient/Other)

_________________________________________ DOB: __________

Medical Record #: __________ Life #: __________ Cellphone #: __________

Shift: Day____ Eve____ Night____ Time:____ Immediate Supervisor: __________

SOURCE Name: _________________________ DOB: __________

SOURCE Medical Record #: __________

SOURCE MD Name: _____________________ MD Pager #: __________

Affix EXPOSED Label Here

Affix SOURCE Label Here

PROCEDURAL STEPS REQUIRED:

- Notify EHS Communicable Disease Program Manager: 646-951-7223 / 57691 M-F 8:30A-4:30 PM
- Email completed worksheet to # EHS MSH PROVIDERS
- Notify Administrator On Call PM’S, WEEKENDS, HOLIDAYS: Dial "0" (Zero)
- Employee Accident/Injury Report: Yes: _____ No: ______
- EMPLOYEE/PERSON EXPOSED sent for care: Yes: ___ No: ______
- (IF PATIENT: NOTIFY Infectious Disease Fellow/Attending)
  EHS* ______ ER______ JMFC/Infectious Disease Clinic** ______ REFUSED____
  [*19 E. 98th Street 2nd floor] [** located in CAM Building 17 E. 102nd Street 3rd floor]
- RISK ASSESSMENT DONE: YES_____NO_____

SOURCE DATA OBTAINED BY INTERVIEW OR CHART REVIEW:
- Every patient needs: (1) GOLD (1) GREEN (1) PEARL TOP TUBE
- Hepatitis B surface antigen (HBsAg) / Hepatitis C antibody (anti-HCV or HCV ab) .....GOLD
- HIV rapid antibody......GREEN
- If positive for Hepatitis B/C or HIV add PEARL top tube: Done: ______ N/A: ______
- If known HIV positive add LAVENDER top tube: Done: ______ N/A: ______
- CD4: _________ Date: __________ Viral Load: __________ Date: _______
- HIV medications:

- If Unable to consent:
  Anonymous Code: __________

Affix Anonymous Code Label Here

Method: Chart review_____ Interview Patient/family_____ MD_____ Nurse_____

Completed By: ______________________ Ext: ______________ Pager# _______

rev.3/2/18_BBFE Worksheet