

SUBLIMITY FIRE DISTRICT

Bloodborne/Airborne Pathogens Exposure

FORM 5041.B

REQUEST FOR SOURCE INDIVIDUAL HIV/HBV/CONFIRM TB SEROLOGICAL TESTING

TO THE EMERGENCY DEPARTMENT PHYSICIAN/ATTENDING PHYSICIAN:

RE: (Name of Source Individual) _____
Incident Date: _____

I have had an exposure to blood, bodily fluids, and/or airborne pathogens in the course of emergency services as defined under OAR 437, Div 2,Z (per 29 CFR 1910.1030) and have identified the source individual to you above. In accordance with OSHA regulations and Sublimity Fire District policy I am requesting that you obtain test the identified source individual for the bloodborne pathogens, HIV and HBV, and/or confirm TB, and that you communicate the results of the testing to the Fire Departments physician, Dr. David W. Foster, who will be conducting the mandatory exposure evaluation. Results of any testing remain confidential in accordance with all applicable state and federal regulations.

Please make every effort possible to obtain consent and to provide the test results to Doctor Foster.

Sublimity FD Member (print) _____

Signature: _____

Forward results in confidence to:

SUBLIMITY FIRE DISTRICTS PHYSICIAN ADVISOR.

Dr. David Foster
Santiam Memorial Hospital

SUBLIMITY FIRE DISTRICT

HEPATITIS B VACCINATION CONSENT/RELEASE FROM LIABILITY

Member (print) _____
Member DOB _____
Soc.Sec.No. _____

I have received training concerning my potential occupational exposure to bloodborne pathogens including HEPATITIS B infection and concerning the HEPATITIS B vaccine. I have received and reviewed information explaining the illness and the vaccine and have had the opportunity to ask questions and confer with healthcare professionals about the benefits and risks of HEPATITIS B vaccination, it's safety, efficiency, precautions, and possible adverse reactions.

I understand that to be fully effective the vaccine will be administered in 3 timed doses (approximately 0 day, 30 day and 180 day). I understand also that there is no absolute guarantee that a vaccinated person will become immune. I acknowledge that bloodborne pathogen precautions are a necessary defense against accidental infection.

I hereby request the Hepatitis B vaccination series. I hereby release and agree to hold harmless the Company and the SUBLIMITY Clinic and their personnel for adverse or untoward results arising from my vaccination against Hepatitis B. I understand that a copy of this consent and certification will be given to me for my own records at the completion of the series but that the original record is the property of the Company and will become a part of its business records.

Member Signature _____ Personnel # _____
Date _____

Dose _____
Date Admin _____
MFG and Lot # _____
Site _____
Hospital Staff Signature _____
Dose 1. _____
Dose 2. _____
Dose 3. _____
Titers Results (Attach form) _____
ADD'L _____

TUBERCULOSIS SCREENING PROGRAM
TEST RECORD

A possibility of job-related exposure to respiratory infectious diseases (including Tuberculosis) exists and as a condition of employment periodic screening for Tuberculosis infection is conducted.

I authorize SUBLIMITY Fire District and its medical providers to administer tests and to maintain and release records of test interpretations and results as may be necessary for administrative and medical care purposes.

EMPLOYEE _____
SSN: _____
SIGNATURE _____
DATE: _____

Note: Reactivity to the Mantoux (PPD) test may be suppressed and inaccurate for as long as 5-6 weeks in individuals who have been recently vaccinated for certain viral illnesses (measles, influenza), who have had recent viral infections (measles, mumps, rubeola or others) or who are receiving corticosteroids or immunosuppressive drugs.

- * Highly sensitive persons may experience ulceration or vesiculation at the injection site. Pain and discomfort are possible but not common.
- * Severe reactions should be reported to the clinic immediately.
- * Persons who have a history of TB or positive reaction will react strongly and should not be tested by this method.

TEST RECORD

1) Intracutaneous injection _____
Site: R or L forearm 4" below bend of elbow
Date: _____ time: _____ hrs
Dose: 5TU/0.1 ml TPPD - Tubersol/Connaught
By: _____

2) Reaction Reading - 48 to 72 hrs after step 1 above
DATE: _____ TIME: _____ HRS POST
INJ: _____

3) Screening Interpretation (circle letter of correct category)
A. NEGATIVE - induration of less than 5 mm:
B. QUESTIONABLE - induration of 5 mm to 9 mm:
C. POSITIVE - induration of 10 mm or more:
D. SEVERE REACTION - pain, fever, swelling, or rash
see note below regarding follow-up interpretation for B,C,D.

4) Definitive Interpretation: POSITIVE / NEGATIVE
by _____ date: _____

Note: Severe reactions, positive screens and questionable results are to be seen at the clinic or at Stayton Hospital ER immediately for professional interpretation and appropriate follow-up diagnostic or palliative care.

SUBLIMITY FIRE DISTRICT

