Blood/Body Fluid Exposure (BFE) Checklist

Exposed Person = recipient (employee, student, etc.)
Source (Donor) = from whom the fluid came (usually the patient)

Key Responsibilities**:**

☐ Unit Nurse Supervisor – Assist Source & Recipient to complete consent & assessment forms (pages 2-9).

☐ Exposed Person – Complete Recipient consent forms and BFE exposure assessment (pages 6-9).

☐ Provider (ED/EOHS/OHS/SHAC) – Review injury, source assessment & counsel Recipient (pages 10-14).

☐ Discharging Nurse/Provider (ED after hours) – Give follow up instructions & ensure correct documentation routing (bottom of page 10).

Unit Nurse Supervisor
Complete before sending exposed person to ED or EOHS or OHS or SHAC

Blood/Body Fluid Exposure (BFE) Checklist

Exposed Person = recipient (employee, student, etc.)
Source (Donor) = from whom the fluid came (usually the patient)

☐ Assist with completion of:

- ☐ Source Patient Risk Assessment & Testing Action Plan (page 3).
- ☐ Source Patient Needle Don consent if indicated/possible (pages 4-5, utilize translator as needed).
- ☐ Ordering Needle Donor (Needle Don) panel with Stat priority in PowerChart if indicated (page 3).
- ☐ Exposed person HIV, Hep B and Hep C consent (pages 6-7).
- ☐ Exposed person BFE Assessment (pages 8-9).

☐ ***Do not*** order or draw any blood from exposed person.

☐ Send exposed person with BFE Checklist packet to:

- ☐ UNMH employee: OHS (M-F 0730-1600) – *or* – ED (after hours).
- ☐ UNM SOM Medical Staff (Physicians, Fellows & Residents): EOHS (M-F 0800-1600) – *or* – OHS (M-F 0730-1600 for initial visit) – *or* – ED (after hours).
- ☐ UNM Students: SHAC (generally M-F 0800-1700 subject to change – *or* – ED after hours).
- ☐ Contract hospital workers, non-UNM students, etc.: Location designated by their employer or school.

☐ If sending exposed person to ED (after hours):

- ☐ Inform ED Charge RN (925-6117).
- ☐ Inform exposed person to:
  - ☐ Print their immunization record (Intranet>Web Based Systems>Occupational Health DB).
  - ☐ Contact their designated occupational health department after discharge for follow up visit.

  – *and* –

  - ☐ Retain entire BFE packet upon discharge (if **NOT** going home before follow up visit).

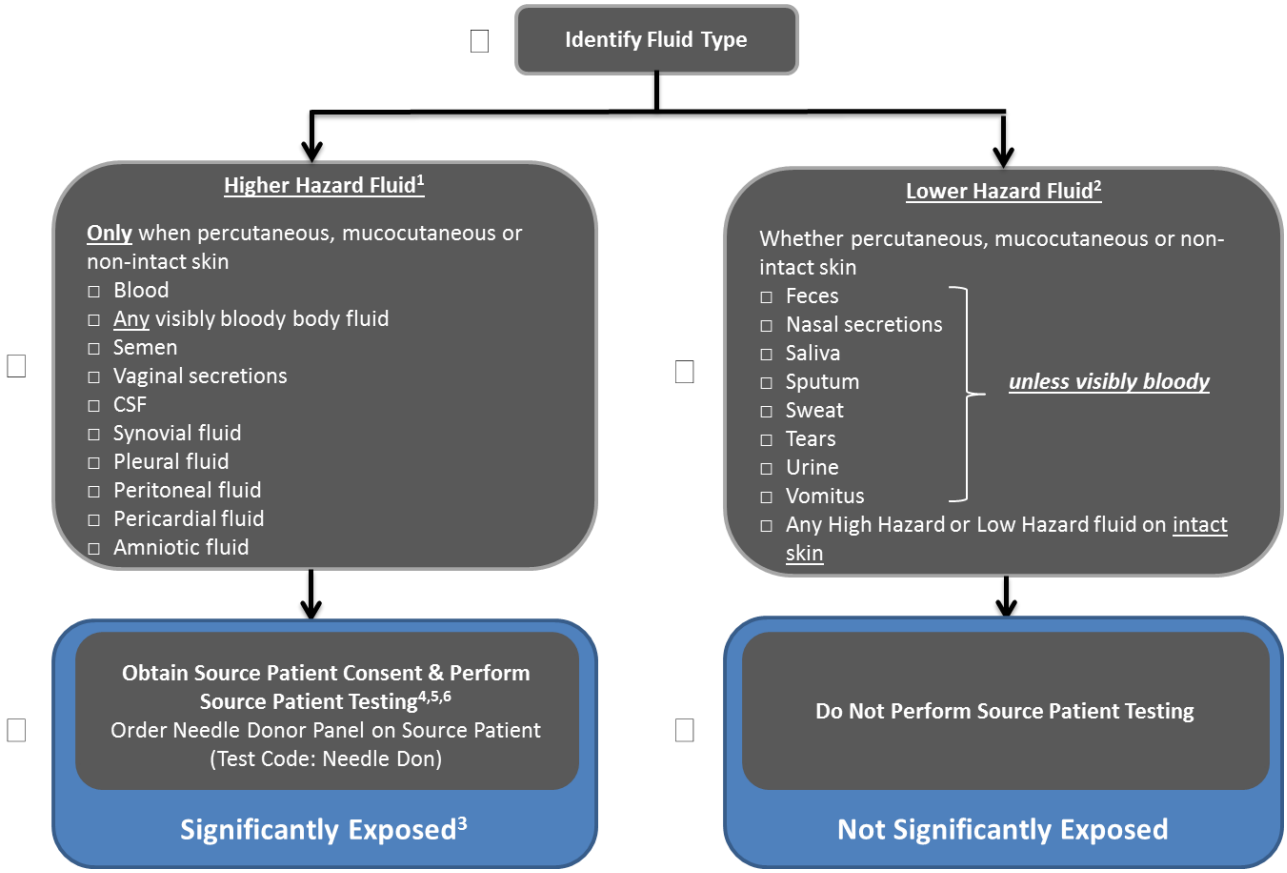
  – *or* –

  - ☐ Deposit entire BFE packet in OHS lock box in ED Triage (if going home before follow up visit).

Unit Nurse Supervisor
Complete before sending exposed person to ED or EOHS or OHS or SHAC

Source (Donor) Risk Assessment & Testing Action Plan

Source Name (or □ unknown):			**MRN :**
Source history of:	HIV Y / N / Unk.	Hep B Y / N / Unk.	Hep C Y / N / Unk.



Source blood draw:	Needle Don ordered Y / N	Source refused testing Y / N

[1] Fluids identified by the CDC as carrying a risk of bloodborne pathogen transmission (HIV, Hepatitis B, Hepatitis C).

[2] Fluids identified by the CDC as not carrying a risk of bloodborne pathogen transmission (unless visibly bloody).

[3] Per New Mexico Statute 24-2B-5.3, "'significantly exposed' means direct contact with blood or other potentially infectious material of a source individual in a manner that is capable of transmitting the human immunodeficiency virus."

[4] Per New Mexico Statute 24-2B-5.3, informed consent is not required for source patient testing, however per UNMH policy *HIV Testing and Reporting* , "Providing an explanation of HIV testing in effort to obtain source patient's informed consent **is strongly recommended in the setting of an occupational exposure**. Informed consent for HIV testing and obtaining authorization for disclosure may be obtained concurrently."

[5] If source patient is under 9 months of age, the source risk assessment and source blood draw are done on the mother.

[6] May be ordered as an add-on to a CH7 (Chem7) previously drawn in the last 72 hours.

_____ _____
Nurse Signature **Date**

Source (Donor) Label

Unit Nurse Supervisor
Complete on Source Patient before sending exposed person to ED or EOHS or OHS or SHAC

Source Patient Consent for HIV, Hepatitis B and Hepatitis C Testing

1. I, _____ of _____
   Name Address (Street, P.O. Box Number)

   _____ /_____/_____
   City State Zip Code

   Hereby consent for the University of New Mexico Health Sciences Center ("UNMHSC") to perform a blood test in order to detect whether I have human immunodeficiency virus (HIV), Hepatitis B or Hepatitis C. This test is performed by withdrawing a sample of blood and conducting laboratory tests to screen for the presence of HIV, Hepatitis B or Hepatitis C.

2. I understand that I may benefit from testing. I understand that testing is mandatory if the exposure to an exposed individual was significant. I understand that testing is voluntary if the exposure to the exposed person was not significant. I understand that care will not be withheld should I refuse to consent to voluntary testing.

3. I understand that a positive HIV test result does not necessarily mean that I have or may develop Acquired Immunodeficiency Syndrome (AIDS), nor does a negative result guarantee that I do not have or will not develop AIDS. I have been informed and understand that HIV antibody test results, in a small percentage of cases, may indicate that a person has antibodies to the virus when the person does not have the antibodies (a false positive result) or that the test may fail to detect that a person has antibodies to the virus when the person does in fact have these antibodies (a false negative result).

4. I understand that the provider's orders for the HIV, Hepatitis B and Hepatitis C tests, test results and my signed consent for the tests will be maintained in my medical record in a confidential manner by UNMHSC and will not be disclosed without my authorization or as required or permitted by law. Any disclosure of my HIV records will be accompanied with a statement that records are not to be re-disclosed without my authorization or as required or permitted by law.

5. I acknowledge that the proposed HIV, Hepatitis B and Hepatitis C tests have been satisfactorily explained to me and my questions have been answered.

_____/_____
Patient or Legally Authorized Representative Signature Date

_____
Printed Name (if different from patient)

Two witnesses are required for telephonic consent:

Witness #1: _____ Witness #2: _____

Source (Donor) Label

Unit Nurse Supervisor
Complete on Source Patient before sending exposed person to ED or EOHS or OHS or SHAC

Source Patient Acknowledgement and Authorization to Disclose HIV, Hepatitis B and Hepatitis C Results

- I understand that disclosure of my HIV test results will be made without my authorization only as required or permitted by law. These legally mandated or permissible disclosures which do not require my authorization or permission include disclosure to the Department of Health/Public Health and to the health care worker who, while rendering care, became significantly exposed to my blood or other potentially infectious material.

- I understand that it may be important for the person exposed that his or her health care provider know the results of my HIV, Hepatitis B and Hepatitis C tests and I hereby authorize the disclosure of my test results to the provider of health care services to the health care worker who was significantly exposed to my blood while rendering care.

- I also understand that I have the right to authorize disclosure of my HIV, Hepatitis B and Hepatitis C test results to any person or agency I choose. I hereby authorize the disclosure of my HIV, Hepatitis B and Hepatitis C test results to the following individual(s)/agency:

  _____
  Name of person or agency to whom disclosure is to be made

- Disclosure of HIV, Hepatitis B and Hepatitis C test results to the above individual(s)/agency may be by:

  ☐ US mail, address/zip: _____/_____
  ☐ Fax number:(____)_____
  ☐ E-mail address: _____
  ☐ Method chosen by UNMHSC
  ☐ Other (please specify): _____

- Disclosure of my HIV test results shall be accompanied by the following or similar statement:

  "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county **j**ail for a define term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500) or both."

- I understand that I have the right to revoke these authorizations at any time except to the extent that disclosures have already been made in reliance of my prior authorizations or as required or permitted by law.

  _____/_____
  Patient or Legally Authorized Representative Signature Date

  _____
  Printed Name (if different from patient)

  Two witnesses are required for telephonic consent:

  Witness #1: _____ Witness #2: _____

Source (Donor) Label

Exposed Person
(Recipient)
Complete before coming to ED or EOHS or OHS or SHAC

Exposed Person Consent for HIV, Hepatitis B and Hepatitis C Testing

1. I, _____ of _____
   Name Address (Street, P.O. Box Number)

   _____ /_____/_____
   City State Zip Code

   Hereby consent for the University of New Mexico Health Sciences Center ("UNMHSC") to perform a blood test in order to detect whether I have human immunodeficiency virus (HIV), Hepatitis B or Hepatitis C. This test is performed by withdrawing a sample of blood and conducting laboratory tests to screen for the presence of HIV, Hepatitis B or Hepatitis C.

2. I understand that I may benefit from testing but that testing is voluntary and care will not be withheld should I refuse.

3. I understand that a positive HIV test result does not necessarily mean that I have or may develop Acquired Immunodeficiency Syndrome (AIDS), nor does a negative result guarantee that I do not have or will not develop AIDS. I have been informed and understand that HIV antibody test results, in a small percentage of cases, may indicate that a person has antibodies to the virus when the person does not have the antibodies (a false positive result) or that the test may fail to detect that a person has antibodies to the virus when the person does in fact have these antibodies (a false negative result).

4. I understand that the provider's orders for the HIV, Hepatitis B and Hepatitis C tests, test results and my signed consent for the tests will be maintained in my medical record in a confidential manner by UNMHSC and will not be disclosed without my authorization or as required or permitted by law. Any disclosure of my HIV records will be accompanied with a statement that records are not to be re-disclosed without my authorization or as required or permitted by law.

5. I acknowledge that the proposed HIV, Hepatitis B and Hepatitis C tests have been satisfactorily explained to me and my questions have been answered.

_____/_____
Patient or Legally Authorized Representative Signature Date

Two witnesses are required for telephonic consent:

Witness #1: _____ Witness #2: _____

Exposed Person (Recipient) Label

Exposed Person
(Recipient)
Complete before coming to ED or EOHS or OHS or SHAC

Exposed Person Acknowledgement and Authorization to Disclose HIV, Hepatitis B and Hepatitis C Results

- I understand that disclosure of my HIV test results will be made without my authorization only as required or permitted by law. These legally mandated or permissible disclosures which do not require my authorization or permission include disclosure to the Department of Health/Public Health and to another exposed individual who became significantly exposed to my blood or other potentially infectious material (in the case of a double/reverse exposure).

- In the case of a double/reverse exposure, I understand that it may be important for the other person exposed that his or her health care provider know the results of my HIV, Hepatitis B and Hepatitis C tests and I hereby authorize the disclosure of my test results to the provider of health care services to the other person who was significantly exposed to my blood while rendering care.

- I also understand that I have the right to authorize disclosure of my HIV, Hepatitis B and Hepatitis C test results to any person or agency I choose. I hereby authorize the disclosure of my HIV, Hepatitis B and Hepatitis C test results to the following individual(s)/agency:

  _____
  Name of person or agency to whom disclosure is to be made

- Disclosure of HIV, Hepatitis B and Hepatitis C test results to the above individual(s)/agency may be by:

  ☐ US mail, address/zip: _____/_____
  ☐ Fax number:(____)_____
  ☐ E-mail address: _____
  ☐ Method chosen by UNMHSC
  ☐ Other (please specify): _____

- Disclosure of my HIV test results shall be accompanied by the following or similar statement:

  "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county **j**ail for a define term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500) or both."

- I understand that I have the right to revoke these authorizations at any time except to the extent that disclosures have already been made in reliance of my prior authorizations or as required or permitted by law.

_____/_____
Patient or Legally Authorized Representative Signature Date

Two witnesses are required for telephonic consent:

Witness #1: _____ Witness #2: _____

Exposed Person (Recipient) Label

Exposed Person
(Recipient)
Complete before coming to ED or EOHS or OHS or SHAC

Body Fluid Exposure Assessment

Name _____ Home Phone _____ Cell Phone _____
Work Phone _____ Preferred number to contact ☐ Home ☐ Cell ☐ Work

1. **Date of Incident** _____ 2. **Time of Incident** _____
3. **Department where incident occurred** _____
4. **Assigned Work Department** _____
5. **Job Category** _____
6. **Incident location** (ED, patient room, OR, lab, etc.) _____
7. **Is the source patient known** ☐ Yes ☐ No

PLEASE NOTE: Complete #8-18 for needlestick/other sharp injury: (For other blood/body fluid exposure skip to #19-28)

8. **Were you the original user of the sharp item?** ☐ Yes ☐ No ☐ Unknown
9. **Did the sharp item have blood visible on it?** ☐ Yes ☐ No ☐ Unknown
   9a. Was the source patient also exposed to your blood from the sharp item ? ☐ Yes ☐ No ☐ Unknown
10. **For what purpose was the sharp item originally used?**
    ☐ Unknown ☐ Injection through the skin ☐ Drawing venous/arterial blood
    ☐ IV use: injection into/aspiration from an IV injection site/IV port, connecting or starting IV
    ☐ Placing a central line ☐ Suturing/cutting/electrocautery ☐ Other _____
11. **How did the injury occur?**
    ☐ During use ☐ After use ☐ Recapping needle ☐ Restraining a patient ☐ Preparation for reuse of reusable equipment ☐ Device left on floor, bed or other inappropriate place ☐ While disposing of item
    Please describe: _____
    _____
    _____
12. **What device was involved in the injury?**
    ☐ Unknown
    ☐ Hollow bore Needle: Identify (gauge of needle, etc)_____
    ☐ Other sharp: Identify (lancet, suture needle, scalpel, glass, etc.) _____
    12a. Brand/Manufacturer of the sharp item:_____Model (part number):_____
13. **Did the item causing the injury have a "safety design" such as retractable or shielded needle?**
    ☐ Yes ☐ No ☐ Unknown If yes, describe feature _____
    13a. Was the device activated? ☐ Yes, fully activated ☐ Yes, partially activated ☐ No ☐ Unknown
14. **What was the physical location of your injury?** (ex. Right index finger)_____
15. **Was the injury?** ☐ Superficial (little/no bleeding) ☐ Moderate (skin punctured/some bleeding)
    ☐ Severe (deep stick/cut, profuse bleeding)
16. **If the injury was to the hand, did the sharp item penetrate?** ☐ Single pair of gloves
    ☐ Double pair of gloves ☐ No gloves
17. **Are you primarily?** ☐ Right handed ☐ Left handed
18. **Do you think this injury could have been prevented with additional controls in place?**
    ☐ **Yes** ☐ **No** **If yes, please describe :** _____
    _____

Exposed Person (Recipient) Label

PLEASE NOTE: Complete #19-28 for other blood/body fluid exposure (ex. splashes):

19. Type of Body Fluid: (please check)

☐ Unknown ☐ Blood ☐ Other body fluid: list type (Sputum, vomit, etc.)_____

If "other," was visible blood present in the fluid? ☐ Yes ☐ No ☐ Unknown

20. What body part was exposed? (Skin on the right hand, eye, mouth, etc)

_____

21. Did the blood/body fluid: ☐ Touch unprotected skin? ☐ Soak through protective garment or clothing?

22. What barrier garments were worn at the time of the exposure?

☐ None: Were barrier garments available ☐ Yes ☐ No

☐ Gloves

☐ Goggles/eyeshield: Availability: ☐ Worn at all times ☐ Available at bedside ☐ Available in centralized location in ☐ wall dispenser ☐ cart ☐ Pyxis and within ☐10 feet ☐ 25 feet ☐ 50 feet ☐ ≥100 feet

☐ Surgical mask

☐ Gown/apron/lab coat

☐ Other: _____

23. How did the exposure occur? _____

_____

_____

_____

24. Did equipment failure occur? ☐ Yes ☐ No If yes, please specify equipment type and manufacturer:

_____

25. How long was the blood/body fluid in contact with your skin/mucous membrane?

☐ Less than 5 minutes ☐ 5-14 minutes ☐ 15 minutes to 1 hour ☐ Over 1 hr

26. Did you flush/clean area? ☐ Yes ☐ No Comments:_____

27. What was the volume of blood/body fluid? ☐ Unknown

☐ Small (up to 1 teaspoon or 5cc) ☐ Moderate (up to quarter cup or 50cc) ☐ Large (over 50cc)

28. Do you think this injury could have been prevented with additional controls in place?

☐ **Yes** ☐ **No If yes, please describe: _____**

_____

_____

_____

_____ _____

Exposed Person (Recipient) Signature Date

ED/EOHS/OHS Provider to complete below and sign:

Recipient HIV status: _____ Recipient significant medical history: _____

BFE involved visible blood: Yes/No

Received tetanus booster in ED: Yes/No

Additional comments: _____

_____

_____

_____

_____ _____ _____

Provider Signature Provider Printed Name Date

Exposed Person (Recipient) Label

Provider
ED or EOHS or OHS or SHAC

Blood/Body Fluid Exposure Checklist

Exposed Person = recipient (employee, student, etc.)
Source (Donor) = from whom the fluid came (usually the patient)

☐ Review injury, complete and sign provider section of Recipient BFE Assessment (page 9).

☐ Review Source Patient Risk Assessment (page 3) and source patient chart as needed.

☐ Review Recipient immunization status for tetanus and revaccinate as needed.

☐ Counsel Recipient regarding (page 14):

- ☐ Bloodborne pathogens of concern.
- ☐ Precautions to decrease risk of secondary transmission.
- ☐ Need to follow up with their designated occupational health service.

☐ Review HIV Transmission Risk decision tree with Recipient and check applicable flow boxes (page 11).

☐ Review HIV PEP Action Plan decision tree with Recipient and check applicable flow boxes (page 12).

☐ If in ED (after hours) :

- ☐ Begin PEP after pregnancy test and give remaining PEP doses in Take Home Pack to Recipient.
- ☐ ***Do not*** order or draw HIV, Hep B or Hep C on Recipient (Completed by EOHS, OHS or SHAC).

ED (After Hours)
Discharging
Nurse or Provider

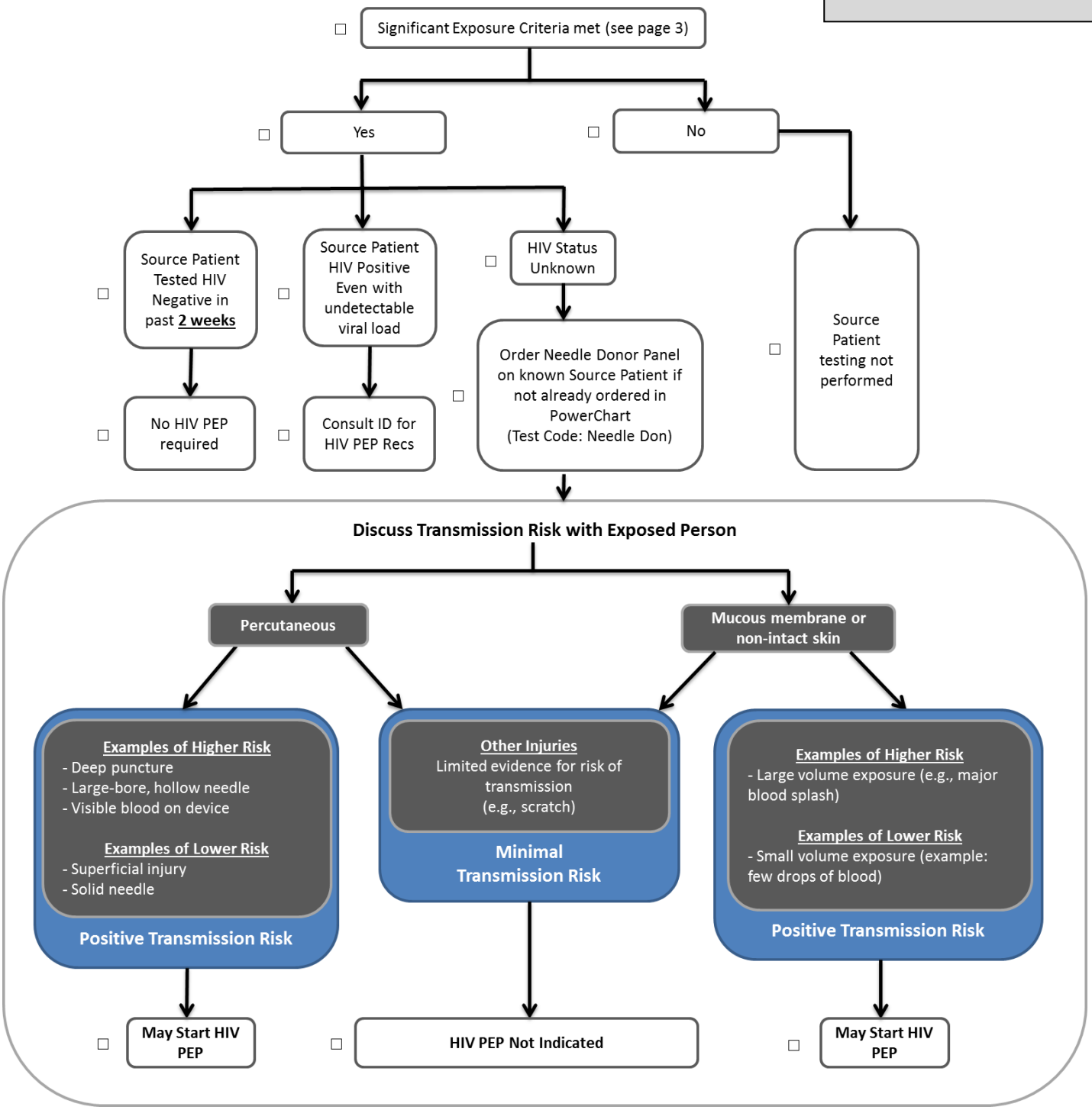
☐ Ensure follow up instructions have been given and are understood (page 14).

☐ Ensure all associated documentation not generated in FirstNet/Powerchart is routed correctly:

- ☐ If BFE occurred when performing duties while employed by UNM/UNMH or as a student of UNM and Recipient is **not** going home before follow up, then Recipient retains all documentation.
- ☐ In all other cases than above, provide copy of last two pages of BFE packet to Recipient (pages 13-14) and ensure Recipient deposits packet and any other documentation in OHS lock box in ED Triage.

Provider
ED or EOHS or OHS or SHAC

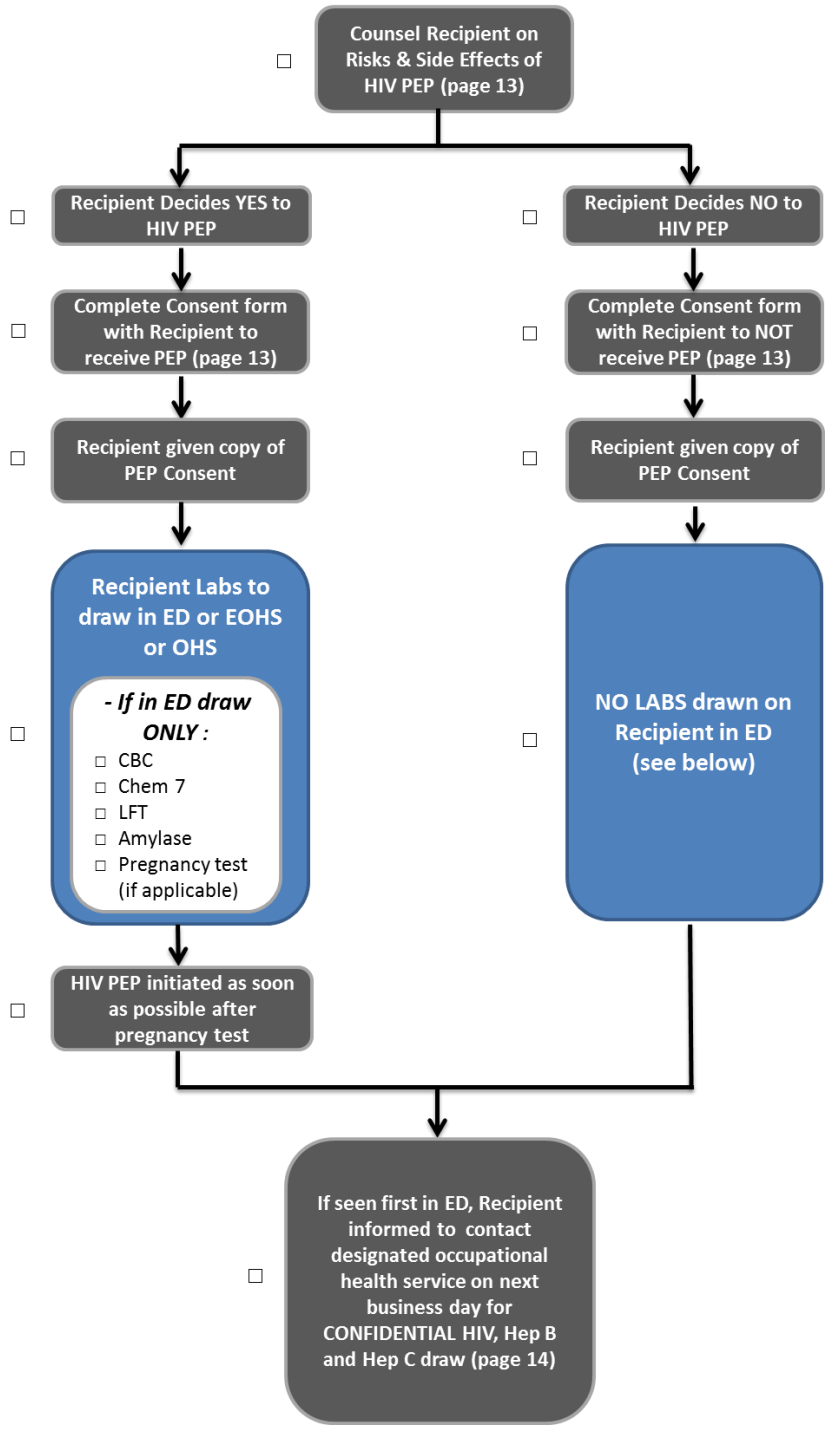
Assessment of HIV Transmission Risk



- Consult the Adult Infectious Disease (ID) physician on-call via PALS or Am I On when:
  - Source patient (Donor) is known to be HIV positive no matter the viral load.
    - Immediate consultation with Adult Infectious Disease is mandatory for determining the best HIV PEP regimen.
  - Exposed Person (Recipient):
    - Is pregnant or breast feeding.
    - Has serious underlying illness (e.g. renal disease).
    - Is taking many medications (e.g. drug-drug interactions need to be reviewed).
  - You have any other questions or concerns.

Provider
ED or EOHS or OHS or SHAC

HIV Post Exposure Prophylaxis (PEP) Action Plan



- If the exposure is high-risk, give the first dose of PEP as soon as possible. There is minimal risk of side effects if given while awaiting:
  - Source patient HIV test results.
  - Informed consent for HIV testing/results release.
  - Expert consultation (if >2 hour wait).

DOCUMENTATION OF COUNSELING FOR POST-EXPOSURE PROPHYLAXIS FOR HIV

I have been potentially exposed to HIV, the virus that causes AIDS, in my work place. My clinician has offered me treatment with emtricitabine/tenofovir (Truvada) with raltegravir (Isentress). Prophylactic treatment with antiretroviral drugs after HIV exposure is expected to reduce my risk of infection with HIV, but may not be 100% effective.

During the four weeks of treatment and four subsequent weeks (both men and women), I will be asked to use barrier devices like male and female condoms. If I am a woman I will be tested for pregnancy and if I am pregnant, any decision to continue prophylaxis will be made in conjunction with an infectious diseases specialist and my obstetric clinician. I will be asked to contact my clinician immediately if I learn that I am pregnant while I am on the medications. See table below for risks and side effects associated with antiretroviral drugs. Treatment side effects are expected to disappear after treatment is stopped, but could be life threatening or irreversible. New or rare serious side effects, including cancer, birth defects, or other life-threatening diseases, might be recognized in the future.

Standard HIV PEP Regimen:

Truvada (emtricitabine 200mg / tenofovir 300mg)
One 200mg/300mg pill by mouth once a day for 28 days
+
Isentress (raltegravir 400mg)
One 400mg pill by mouth twice a day for 28 days

Medication Name	Common Side Effects	Uncommon Side Effects	Caution
Emtricitabine/tenofovir (Truvada)	-Diarrhea -Nausea -Fatigue -Headache	-Lactic acidosis -Nephrotoxicity -Myopathy	For individuals with: -Renal impairment -Chronic Hepatitis B infection
Raltegravir (Isentress)	-Diarrhea -Nausea -Headache	-Severe rash (contact healthcare provider) -Elevated CK (muscle injury)	-Do not take with antacids or calcium carbonate (inhibit absorption)

For patient handouts on any HIV medications (copy and paste link to browser if unable to open):
Truvada: **http://www.aidsinfonet.org/uploaded/factsheets/57_eng_421.pdf**
Isentress: **http://www.aidsinfonet.org/uploaded/factsheets/80_eng_465.pdf**

☐ I have discussed all of my current medications as listed above with the treating provider and plan to take HIV postexposure prophylaxis.

☐ I have been advised to use other antiretroviral drugs by an Infectious Disease physician and have been informed of their side effects and drug interactions. These medications are:
_____

☐ I HAVE DECIDED NOT TO TAKE HIV PEP OR DO NOT NEED THIS BASED ON EXPOSURE RISK

SIGNATURE: _____ DATE: ___/___/___

WITNESS: _____ DATE: ___/___/____

Exposed Person (Recipient) Label

Body Fluid Exposure Discharge Information

1. There is a possibility that you have become exposed to one or more of the following diseases:

   HIV: Risk of infection by HIV infected **blood** through a needlestick is 0.3%.
   Risk of infection by HIV infected **blood** in the eyes or mouth is 0.09%.
   Risk of infection by HIV infected **blood** through a break in the skin is less than 0.09%.
   Risk of infection by any other body fluid is **much** lower.

   Hepatitis B: Risk of infection is dependent upon many factors and is between 2 and 40% **in an unvaccinated person**.

   Hepatitis C: Risk of infection after a needlestick is 1.8%.

2. It is possible that you could transmit one or more of these diseases to another person, so you should avoid activities that might expose others to your blood or body fluids. These include sharing toothbrushes or razorblades, donating blood or body organs, breastfeeding or becoming pregnant. If you are sexually active, you should consider using condoms with sexual activity. If you are a user of recreational drugs, you should not share needles. These precautions are especially important in the first 6-12 weeks after this exposure.

3. If you have received HIV prophylaxis medication (PEP), make sure that you received a copy of the consent form with information on the drug side effects and drug interactions, and an explanation of the need to continue the PEP regimen.

4. If you were treated in the ED after hours, you will need to contact your designated occupational health service for a follow up appointment where confidential labs will be drawn for HIV, Hepatitis B and Hepatitis C.

   - ☐ **UNMH employees** should follow up at **OHS (**Occupational Health Services **– 272-2517 –** 5 North Main Hospital**)** between 7:30 am and 4:00 pm the next business day.

   - ☐ **UNM faculty or residents** should follow up at **EOHS (**Employee Occupational Health Services **– 272-8043 –** 2nd floor of the Family Practice Building**)** between 8:00 am and 4:00 pm the next business day.

   - ☐ **UNM students** should follow up at **SHAC (**Student Health and Counseling **– 277-3136 –** Main Campus across from the SUB**)** between 8:00 am and 5:00 pm the next business day (*hours subject to change*).

   - ☐ **Contract hospital workers (non-UNM or non-UNMH employees), EMS, non-UNM Students, etc.** exposed at work should contact their employer or school immediately. Additional direction and source patient information can be obtained through Infection Prevention and Control (**272-9722**).

   - ☐ **Other members of the community** should follow up with a Primary Care Provider as soon as possible. Additional direction and source patient information can be obtained through Infection Prevention and Control (**272-9722**).

5. If you were treated in the ED after hours, the exposure occurred when performing duties while employed by UNM/UNMH or as a student of UNM, and you are **not** going home before your follow up: Retain this entire packet, any other documentation you have completed, and bring to your occupational health service. For all other cases treated in the ED: Obtain a copy of previous page and this page (pages 13 & 14) and deposit this entire packet in the OHS lock box located in Triage prior to leaving the ED.

Exposed Person (Recipient) Label