NELL HODGSON WOODRUFF SCHOOL OF NURSING
INCIDENT, INJURY & Pathogen Exposure REPORT

STUDENTS SHOULD COMPLETE THIS FORM; Emory Faculty member will add follow up comments.

NEEDLESTICK HOTLINE: 404-616-4PEM (4736)

Student's Full Name_____

Address_____

Soc Sec #_____-_____-_____Birth Date ____/____/____ email _____

Home Phone _____ Cell Phone _____

Program: BSN MSN Specialty: _____

Student's Immunization Status:
Tetanus _____Hepatitis B Vaccine _____ Titer _____ Last PPD _____Other (specify) _____

Date of Incident: ____/____/____ Time: _____:_____ AM PM

Location/Facility Name:_____
Dept/Unit_____

Type of Facility: Hospital Private Practice Community Agency

Other: _____

Site Preceptor _____

Work Phone & Cell #_____

Site Contact for follow up: _____ Title: _____

Phone _____

TYPE OF INCIDENT

□ Needlestick Type of Needle_____□ Other sharp object _____

□ Other Injury (explain below) □ TB Exposure □ Other (explain below) _____

TYPE OF EXPOSURE

□ Body fluid splash Blood Urine Saliva Wound drainage Animal scratch Animal bite □ Mucous membrane

□ Eye Mouth Nose Broken skin Intact skin Inhalant □ other_____

Who witnessed the incident? _____

To whom at the facility was it reported?_____

When was Emory faculty member notified? _____

Was an incident report created by the site? Yes No Please attach a copy.

Where were you treated for the needlestick? Facility Name: _____

_____

Please attach a copy of the Emergency Center Report _____

Were baseline labs obtained from the source or source patient? No Why not?

Yes Which serology?? _____

_____

Attach copy of results (without patient name) or list: _____

_____

Was acute serology drawn on you (the student)? No

Yes By: _____

Note: what will be tested: (rapid HIV, Hep B, etc.) _____

_____

Did you call the Needlestick Prevention Center Hotline? Yes No

FULLY describe the incident/injury/exposure and explain in detail what you were doing when the injury/exposure/incident occurred, including the use of tools, equipment or materials. What body part was affected? Have you ever required medical treatment for this part of your body or condition before? Please use additional sheets if necessary.

_____

_____

_____

_____

_____

_____

_____

Student Signature _____ Date _____

To be completed by EMORY FACULTY: Clinical Instructor's Comments

In addition: please review and provide additional information/clarification to the student's statement.

Emory Faculty Clinical Instructor _____ Work # _____
Cell Phone #_____

Faculty Member notified: Date _____ Time: _____ AM PM

Faculty Report:

_____

_____

_____

_____

Follow Up Actions by student already conducted and to be conducted (please note timeline)

_____
_____
_____

Are student's clinical activities restricted? No Yes (If yes, please describe and give beginning and end dates for date for review by student's personal health care provider.)

_____
_____
_____

Signatures Department (Chair should also be notified)

Faculty Member/Specialty Coordinator: _____ Date: _____

Assistant Dean for BSN Education: _____

Signature: _____ Date _____

Present original to Assistant Director for Nursing Education within 24 hours

Date Received by Office of Education _____ by _____

Notes:

_____
_____

Updated 2/2015