



## Bloodborne Pathogen Exposure Procedure for Students

A University of Rhode Island (URI) student or intern who sustains an exposure from a needle stick, instrument stick, or mucous membranes to non-intact skin will follow the University procedure for treatment and reporting procedures.

1. In the *event* of an exposure to blood or other potentially infectious materials, the student is to immediately notify their clinical instructor, site supervisor, or Principal Investigator.
2. If at a clinical site, follow clinical site's bloodborne pathogen exposure policy, which should include washing the area with soap and water.
3. If in URI laboratory or facility, follow URI's Bloodborne Pathogen Exposure procedure, which includes washing the area with soap and water. If there is no obvious laceration or major abrasion, the student may choose to wash with soap and water.
4. Report to either Student Health Services if the incident occurs on campus or the closest Emergency Room or medical facility (depending on the location of the incident) for immediate treatment. Student Health Services may advise the student to immediately report to South County Hospital Emergency Room or the treating ER physician for further review of risk assessment and evaluation of exposure; treatment, counseling and testing, if indicated.
5. Student is to report all pertinent data to the treating physician regarding the exposure and information on source patient. This includes but is not limited to: how exposure occurred, what body fluids were involved, social and medical history, HIV antibody status, Hepatitis B surface antigen status, and Hepatitis C antibody status of source patient (or blood sample) if available. For effective treatment of any potential HIV infection it is imperative to initiate prophylactic treatment within the 2 hours of the incident.
6. The student should expect to have blood drawn for baseline results of Hepatitis B surface antibody, Hepatitis C antibody, HIV antibody and possibly other necessary tests. If there is an index of suspicion regarding the source's HIV status, a 48 hour supply of prophylactic medications maybe provided to the student.
7. The South County Hospital Emergency Room physician will:
  - Inform the student of all lab results and any illness that may result from the exposure.
  - Provide necessary prophylaxis in accordance with the current recommendations of the U.S. Public Health Services.
  - Counsel the student concerning precautions to take during the period after the exposure incident.
  - The student will be advised to report to the treating physician any symptoms or illness within 12 weeks of the incident. Should any of these occur, a follow-up appointment will be necessary.
8. The student is to complete the attached Bloodborne Pathogen Exposure Report form along with either the Consent to Blood Test Form or the Refusal of Medical Evaluation Form and forward copies to the University of Rhode Island Risk Manager within 48 hours.

9. For clinical internships, the clinical instructor or supervisor where the incident occurred should notify the URI Program Coordinator of the event.
10. It is **strongly recommended** that the student continue taking medication if prescribed until a final diagnosis is determined. All information will remain confidential.
11. The student's personal medical insurance (or school insurance if purchased) should be used for all medical visits and/or treatments. Any outstanding medical bills should be submitted directly to the University of Rhode Island's Risk Manager for review. (Student may be required to sign a medical release)
12. On-line Resource information: Centers for Disease Control, <http://www.cdc.gov/hai/>

*It is extremely important that students follow these guidelines and report incidents promptly. This avoids problems that may occur later with the processing of the student's health or medical bills.*

**University of Rhode Island**  
BLOODBORNE PATHOGEN EXPOSURE REPORT

**Instructions:** This form is to be used to report all student exposures or injury involving needle sticks, sharps and any other bodily fluid exposures. Complete this form and provide a copy to the University of Rhode Island Risk Manager within 24 hours of the incident.

**Exposed Individual's Information:** Report Date: \_\_\_\_\_

**Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Student ID Number: \_\_\_\_\_

**Exposure Information**

Exposure Date: \_\_\_\_\_ Exposure Time: \_\_\_\_\_

Exposure Location and Description: (Facility, specific location, room, etc.): \_\_\_\_\_

E \_\_\_\_\_

Type and brand of device involved in the incident (needle, lancet, etc.) \_\_\_\_\_

Type of protection equipment used (gloves, goggles, etc.): \_\_\_\_\_

**Type of exposure (stick, splash, puncture, etc.):** \_\_\_\_\_

Type of immediate intervention taken after exposure (area washed, flushed, etc.) \_\_\_\_\_

**Program/Department Information**

URI department or program in which you are enrolled: \_\_\_\_\_

Clinical Instructor/Supervisor: \_\_\_\_\_

Instructor Contact Information: \_\_\_\_\_

**Treatment Information**

Medical facility where injured person was treated: \_\_\_\_\_

Medical treatment rendered: \_\_\_\_\_

Type of follow up treatment needed or anticipated: \_\_\_\_\_

**Return Completed form to:**

Office of Enterprise Risk Management  
University of Rhode Island  
75 Lower College – Suite 118  
Kingston, RI 02881  
riskmanagement@etal.uri.edu  
(P) 401-874-2591 (F) 401-874-9101

# University of Rhode Island

## CONSENT FOR HIV BLOOD TEST

I have been informed that my blood will be tested in order to detect whether or not I have antibodies and/or antigens in my blood to the Human Immunodeficiency Virus (HIV), which is the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood and using a substance to test the blood.

I have been informed that the test results may, in some cases, indicate that a person has antibodies and/or antigens to the virus when the person does not (false positive), or that it may fail to detect that a person has antibodies to the virus when the person has antibodies (false negative). I understand that in order to diagnose AIDS, other clinical evidence must be used in conjunction with this blood test.

I also consent to be tested for Hepatitis B Virus and Hepatitis C Virus at this time.

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks and alternative tests, I may ask those questions before I decide to consent to the blood test.

I understand that the results of the blood test are confidential and will only be released to those healthcare practitioners directly responsible for my care and treatment, and to others as may be required by law. I further understand that no additional release of the results will be made without my written authorization.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood tests and release of results and have had all of my questions answered. Further, I acknowledge that I have given consent for the performance of a blood test to detect antibodies to the Human Immunodeficiency Virus (AIDS).

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Signature

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Date

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University of Rhode Island 75 Lower  
Campus Road, - Suite 118  
Kingston, RI 02881  
riskmanagement@etal.uri.edu  
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**University of Rhode Island**  
INFORMED REFUSAL OF POST EXPOSURE MEDICAL EVALUATION

I, \_\_\_\_\_  
am an active student in the \_\_\_\_\_ program at the University of Rhode Island.

My experiential coordinator has provided me training regarding infection control and the risk of disease transmission in experiential activities.

On \_\_\_\_\_, 20\_\_\_\_, I \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

According to the University of Rhode Island's procedure on blood borne pathogens and bodily injury exposure I should seek initial and/or follow-up medical evaluation to assure that I have full knowledge of whether I have been exposed to or contacted an infectious disease as a result of this incident. However I, of my own free will and volition, and despite the University's procedure, have elected not to have a medical evaluation or follow-up evaluation. I have personal reasons for making this decision.

Signature \_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

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