UNIVERSITY OF NOTRE DAME

MEDICAL SURVEILLANCE FORM FOR PHYSICIANS

Name: _____ NDID#: _____
Job Title: _____ Date of Exposure: _____
Job Risks: _____
Last Tetanus Booster: _____
Hepatitis Vaccination Series Completed? Yes ____ No _____
HBV Immune Status: Immune _____ Not Immune _____

Previous Exposure to Hepatitis? Yes ____ No _____

Type of Exposure:
Needle Stick? Yes ____ No ____
If Yes, Which Body Parts _____

Blood Splash? Yes ____ No ____
If Yes, Which Body Parts _____

Contact to Bare Skin with Blood or Body Fluids? Yes ____ No _____
If Yes, Specify Blood or Bodily Fluid _____

Condition of Skin: _____

Other Medical Information: _____

Source of Exposure Known? Yes _____ No _____
Test Results From Source of Exposure:
Hepatitis B Positive _____ Negative _____
HBIG Recommended? Yes _____ No _____
HBIG Provided? Yes _____ No _____
HIV Surveillance Recommended? Yes _____ No _____

Comments: _____

Data Provided to Physician:
OSHA Standard Yes _____ No _____
Personnel's Medical File Yes _____ No _____
Incident Report: Yes _____ No _____

PHYSICIAN'S SIGNATURE **DATE**

Approval Date: March 2015
Revision Date: