

NAVAL HOSPITAL LEMOORE QUALITY OF CARE FORM – BLOODBORNE PATHOGENS

Print patient's name/status/DOB:			
Date of Event:		Time of Event:	
Location of Event:			
Bloodborne pathogen exposure (select one) Exposure to Blood/Body Fluids <input type="checkbox"/> Needle Stick/Sharps <input type="checkbox"/> Other <input type="checkbox"/> :			
Using factual information only, summarize the occurrence. If needed, continue on blank paper and attach.			
Risk Manager:	Signature	Rank/Rate:	Date:
Name of Person preparing report (print):	Signature: Clinic/Dept:	Rank/Rate/Title:	Date:

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Department/Clinic Review:			
What actions have been taken:			
Name of reviewer:	Signature:	Rank/Rate/Title:	Date:
Directorate Review:			
Name of Director:	Signature:	Rank/Rate/Title	Date:
Occupational Health Nurse Review:			
Name:	Signature:	Rank/Rate/Title:	Date:
Safety Officer Review:			
Name:	Signature:	Rank/Rate/Title:	Date:
Infection Control Committee Review:			
Recommendations/Actions:			
Responsible Party for Action Item(s):			
Voting: _____ Within standard of care/procedure. _____ Not within standard of care/procedure			
Chairman/Representative Name:	Signature	Rank/Rate/Title	Date

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