

## **STUDENT Blood & Body Fluid Exposure Checklist**

**Employees or Residents call Employee Health (585-275-1164)**

\_\_\_\_\_ Wash or irrigate the affected area immediately.

\_\_\_\_\_ Call UHS 585-275-2662 if you are a Student or EIOH Intern

***If the exposure occurred at the following sights:***

- **F.F. Thomspson Hospital** call 585-396-6457
- **Highland Hospital** call 585-341-8017
- **Rochester General Hospital** call 585-922-4026

\_\_\_\_\_ **Speak with nurse manager or Resident.** They will coordinate HIV consent from source person and drawing the blood from source person (Give the nurse the attached consent form).

- ❖ Once signed, the consent should be emailed to UHS: [uhsocchealth@uhs.rochester.edu](mailto:uhsocchealth@uhs.rochester.edu) OR fax it to UHS at 585-461-9636

\_\_\_\_\_ Blood samples collected **at URMHC**: send to the lab, **Micro lab @ tube station #911.**  
UHS will place the order (*do not put in eRecord*).

Blood tubes needed:

**2 SSTs and 2 lavender tubes with Source Patient Name, DOB, & MRN #.**

**Charge nurse or Medical Resident will get consent and have blood drawn.**

**Send samples to Micro lab @ tube station #911**

\_\_\_\_\_ **Pick up PEP medication (if indicated).** Medication will be ordered by UHS Provider at:  
**Strong Memorial Outpatient Pharmacy** (open 24 hours), 601 Elmwood Avenue, Rochester, NY  
14642, Phone: [\(585\) 275-4931](tel:5852754931) (NOT the Employee Pharmacy)

\_\_\_\_\_ **Follow up with UHS Occupational Health** the same day (preferred) or of the following business day if happened after hours. Call: 585-275-4955.



\_\_\_\_\_ Scan the QR Code for helpful information on **infectious disease**:

\_\_\_\_\_ **Report the incident to Environmental Health & Safety at 585-275-3241.**

**Student & Non-employee injury / illness report**





New York State Department of Health AIDS Institute

HIV Test Consent Form

Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agreed to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or person authorized to consent)

Patient Medical Record number: \_\_\_\_\_

## For SMH Onsite locations

Send Source Patient Vacutainer Tubes

(2 SSTs & 2 Lavender tubes must be completely filled)

**STAT** to Micro Tube Station 911

**UHS MEDICALLY**

**URGENT LABS**

(Be sure to label each tube with patient name  
and DOB, but do **not** order anything in eRecord.)

**Fax Consent/Release forms to**

**University Health Service at (585) 461-9636.**

**\*\*SEND THIS FORM WITH SPECIMEN\*\***

***For Offsite Locations***

(Regional hospitals will perform their own source testing protocols,  
i.e. Highland, RGH, Unity, etc.)

**Send Source Patient Vacutainer Tubes**

(2 SSTs & 2 Lavender tubes must be completely filled)

**UHS Medically**  
**Urgent Labs**

**SMH Outpatient Lab:** Take to Inpatient Lab **IMMEDIATELY**

**For Off-site Locations:** Call SMH Client Services at  
(585) 758-0510, Option #3

**Arrange Courier Services to pick-up “STAT” Specimen**

Instruct courier to deliver specimens  
**directly to SMH Micro Lab.**

**\*\*SEND THIS FORM WITH SPECIMEN\*\***