As a prospective Dental Assisting student, you will be exposed to radiation, blood-
borne pathogens and communicable diseases.

**OCCUPATIONAL EXPOSURE TO COMMUNICABLE DISEASES**
Dental Assistants need to make sure they fully understand the risk of communicable diseases. A communicable disease is one that is transmitted by saliva, blood, and other bodily fluids. Dental Assistants are at a very high risk because their hands come into contact with patients’ mouths all day long. This exposes them to saliva and often blood. While patients are asked to disclose information about communicable diseases including HIV, many choose not to. Some communicable diseases such as herpes form sores in the mouth and Dental Assistants need to be able to identify them. A Dental Assistant should assume every patient is contagious and take all precautions against infection.

**OCCUPATIONAL EXPOSURES TO BLOOD**
Dental healthcare personnel are at risk for occupational exposure to blood-borne pathogens, including hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV). Exposures occur through needle sticks or cuts from other sharp instruments contaminated with an infected patient’s blood or through contact of the eye, nose, mouth, or skin with a patient’s blood. Important factors that influence the overall risk for occupational exposures to blood-borne pathogens include the number of infected individuals in the patient population and the type and number of blood contacts. Most exposures do not result in infection.

Employers and clinical sites should have in place a system for reporting exposures in order to quickly evaluate the risk of infection, inform you about treatments available to help prevent infection, monitor you for side effects of treatments, and determine if infection occurs. This may involve testing your blood and that of the source patient and offering appropriate post-exposure treatment.

**HOW CAN OCCUPATIONAL EXPOSURES BE PREVENTED?**
Many needle sticks and other cuts can be prevented by using safer techniques (for example, not recapping needles by hand), disposing of used needles in appropriate sharps disposal containers, and using medical devices with safety features designed to prevent injuries. Using appropriate barriers such as gloves, eye and face protection, or gowns when contact with blood is expected can prevent many exposures to the eyes, nose, mouth, or skin.

**OCCUPATIONAL EXPOSURE TO IONIZING RADIATION**
Dental personnel work with ionizing radiation daily. The State of South Dakota requires that all dental assistants must be educationally trained in the proper use of radiographic equipment and techniques for exposing radiographs safely. Students will follow mandated instructions regarding patient exposure and radiation asepsis for operators.
Exposed Person __________________________ Phone number ______ Date of report ______
Date of exposure ______ Time of exposure ______ Supervisor/Faculty ________________

Source Information

Name of Source ____________________________ Date Source Notified ________________
Perform the tests listed below immediately.
Date Source Specimen Drawn ____________________________

Source Results:

- HIV 1/2:  [ ] positive  [ ] negative  [ ] not tested
- Anti-HCV: [ ] positive  [ ] negative  [ ] not tested
- HBsAg:  [ ] positive  [ ] negative  [ ] not tested

Date Source Results Reported ____________________________

Source Consent

I have been notified that a blood borne exposure occurred with my blood. As the source of this exposure, I consent to have my blood drawn for the following tests: HIV 1/2, Anti-HCV and HBsAg. I realize the importance for the results of these tests to be shared with the clinician as well as the faculty of LATI in order to determine further testing requirements of the exposed person. Therefore, I consent to release the information for these lab tests to ______________________________ a member of the Faculty of the ______________________________ program at Lake Area Technical Institute.

I am aware that the cost of the testing will be paid for by Lake Area Tech.

Source Name ____________________________ Source Signature __________________ Date ______

LATI Faculty Name _______________________ LATI Faculty Signature __________________ Date ______
Lake Area Technical Institute

POST EXPOSURE REPORT FORM

Name _____________________________ Phone number __________________ Date of report ________________

Date of exposure __________ Time of exposure ____________ Supervisor/Faculty ________________

Program: DA  MFR  MA  MLT  Nursing  OTA  PTA  HST  Staff

Site (building) where exposure occurred __________________________ City/State __________________

Was this a clinical site? ________ (if yes, clinical facility’s post exposure plan must be followed)

Details of Exposure: To be Completed by the Student/Staff

Type of Body Fluid Exposure (check all that apply)

Unable to identify

Component: (prbc, plasma, platelets)

Blood

Bloody nasal secretions

Wound drainage

Peritoneal/pleural/pericardial/synovial

Vaginal secretions

CSF/Amniotic Fluid/Semen

Details of the procedure being performed; including where and how the exposure occurred / types of sharps involved, etc.

Extent of exposure (type and amount of blood/body fluid/material, severity of exposure including depth and whether fluid was injected, etc.)

Personal Protective Equipment worn:

☐ gloves  ☐ gown  ☐ mask  ☐ protective eyewear  ☐ face shield

other PPE (describe): __________________________

Decontamination utilized (i.e. hand washing, flushing mucous membrane eye, nose, mouth, etc.) __________________________

Description of first aid administered __________________________

Route/Type(s) of Exposure (check all that apply)

Type 1: Splash to mucous membranes

☐ eye  ☐ nose  ☐ mouth  ☐ other:

Type 2: Contaminated skin penetration other than needlestick

☐ puncture  ☐ human bite

☐ Open/healing sore, wound or lesion (location)

☐ eczema, skin rash, non-intact skin (location)

☐ pierced ears  ☐ other

Type 3: Needlestick

☐ contaminated  ☐ non-contaminated

Type 4: Contact with intact skin or clothing

☐ wet drops/spray on clothing, no skin contact

☐ fluids soaked through clothing with skin contact

☐ clothing contact with dried/caked blood, no skin contact

☐ skin contact with dried/caked blood  ☐ other:

Interpretation – Follow-Up Activities

Type 1 or 2 exposure

☐ Send worker for medical evaluation

Type 3 exposure

☐ Contaminated needle, handle as a Type 1 and send for medical evaluation

☐ Non-contaminated needle, fill out form for tracking only – considered a non-exposure

Type 4 exposure

☐ If occurs with Type 1/2/3 exposure: handle as the more serious type

☐ With NO type 1/2/3 exposure: Have exposed person change contaminated clothes / wash up immediately. Fill out form / maintain on file. Counsel/review work practices to prevent re-occurrence. Modify written exposure control plan and/or train others with similar exposure potential if indicated

I consent to the release of information such as immunization and immunity status to the LATI program, the clinical facility and the site providing my post-exposure counseling and management. I also consent to the release of the post-exposure serology test results to LATI and the clinical facility. I realize that I must follow the testing interval guidelines set forth in this document or as required by my clinical facility site (if currently on clinical during the time of exposure). If I fail to do so, I will be required to pay for my own medical bills related to this exposure.

Signature: __________________________ Date: ____________________
All student exposures occurring at LATI must be referred to one of the physicians below for consultation (this form is to accompany the student and a copy should be returned to the program after they are seen)

☐ Brown Clinic Physician: Dr Aaron Shives  ☐ Sanford Clinic Physician: Dr. William Devine

☐ After clinic hours: Acute care or PLH

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**Source Patient:**

Was the source patient identifiable? yes ☐ no ☐ (if no, it is not necessary to answer the remaining questions in this section but please continue to the post-exposure Student Baseline section below)

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Did the source complete the SOURCE CONSENT FORM? ☐ yes ☐ no

Did the source sign the medical release portion? ☐ yes ☐ no

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**Perform the following tests immediately on the source:**

HIV 1/2: date drawn _____________ positive ☐ negative ☐ not tested ☐

Anti-HCV: date drawn _____________ positive ☐ negative ☐ not tested ☐

HBsAg: date drawn _____________ positive ☐ negative ☐ not tested ☐

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**IF SOURCE IS NEGATIVE FOR THE TESTS ABOVE, NO FURTHER TESTING IS REQUIRED**

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**Post Exposure Baseline:**

Hepatitis B immunity status: Date of last tetanus booster: _____________

Series completed: ☐ yes ☐ no ☐ unknown

Post immunization titer (HBsAb): ☐ protected ☐ negative ☐ unknown

IF EXPOSED PERSON IS KNOWN TO HAVE HBsAb PROTECTIVE TITER, THE HBsAg, HBcAB and HBsAb tests ARE NOT REQUIRED

Date Baseline Testing Drawn _______________ Facility ______________________________________

Test Instructions: ☐ save specimen until source testing results are known ☐ test immediately (source unknown)

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HIV 1/2: ☐ yes ☐ no

Anti-HCV: ☐ yes ☐ no

Hepatitis B core antibody ☐ yes ☐ no ☐ not tested – has known protective immunity (HBsAb)

Hepatitis B surface antigen ☐ yes ☐ no ☐ not tested – has known protective immunity (HBsAb)

HBsAb ☐ yes ☐ no ☐ not tested – has known protective immunity (HBsAb)

Other tests ordered/performed __________________________ Date ______ Results received _________________

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**Post-exposure Management After Baseline Testing:**

Hepatitis B:
Recommendations: ☐ No further follow up required ☐ HBIG (date; dose) __________________________

☐ Additional recommendations __________________________

Hepatitis C:
Recommendations: ☐ No further follow up required ☐ HCV 6 mo

☐ Additional recommendations __________________________

HIV:
Recommendations: ☐ No further follow up ☐ HIV testing at 6 wks and 6 months

Further recommendations for post-exposure management and follow-up __________________________

Counseling included topics of: __________________________

Post-exposure consultation by: __________________________ Date: __________________________

(Signature)

(Please Print Name)

Facility name and city: __________________________ Phone: __________________________