FIRST RESPONDER PROVIDER REQUEST
FOR HIV and/or HEPATITIS B TESTING OF EMERGENCY PATIENT

In Accordance with Michigan Public Act 419 of 1994 (MCL 333.20191)

Michigan Department of Community Health

NOTICE TO EXPOSED INDIVIDUAL:

- Test results will not be provided over the telephone.
- This request should be made before the emergency patient is released from the health care facility.
- Please contact the health care facility if the interpretation of test results on the emergency patient is not received by you within ten (10) days.
- **Information contained on this form is confidential.**
- See page 2 for PA 431 and non-discrimination information.

SECTION 1 – To be completed by EXPOSED INDIVIDUAL: *(Please Print)*

1. Name of Exposed Individual			3. Job Classification		
2. Home Address (Number & Street, etc.)			☐ **Good Samaritan**		
City	State	ZIP Code	4. Home Phone Number ( )		
5. Name of Employer			7. Employer Phone Number ( )		
6. Employer Address (Number & Street, etc.)			City	State	ZIP Code
8. Emergency Source Patient ID No.	9. Date of Exposure		10. Approximate Time of Exposure : ☐ **AM** ☐ **PM**		

11. Route of Exposure:

☐ **Open Wound** ☐ **Mucous Membrane** ☐ **Percutaneous** ☐ **Other**

12. Provide a detailed description of the exposure: *(Attach an additional sheet as needed)*

13. Personal Protective Equipment used when exposed: *(Check all that apply)*

☐ **Glove** ☐ **Gown** ☐ **Eye Protection** ☐ **Face Mask**
☐ **Turnout Gear** ☐ **NONE** ☐ **Other** (explain):

14. Based on my exposure described above, I am requesting that this source individual be tested for the following: *(Check all that apply)*

☐ **HIV** ☐ **Hepatitis B** ☐ **Other** (explain):

15. Where do you want the Test Results Sent to: *(Check all that apply)*

☐ **Me at my Home** (Address Above) ☐ **My Physician** *(Complete item #**16** below)*
☐ **Me at Work** (Address Above) ☐ **Other Health Care Professional** *(Complete item #**17** below)*

16. Name of Your Physician		Physician Phone Number ( )	
Physician Address (Number & Street, etc.)	City	State	City
17. Name of Other Health Care Professional		Other Health Care Professional Phone Number ( )	
Other Health Care Professional Address (Number & Street, etc.)	City	State	City

- I understand that the NAME of the source individual to be tested, and that person's test results are confidential according to Section 5131 of Michigan Compiled Laws (MCL). I understand that a person who discloses information in violation of this Section is guilty of a misdemeanor.
- I also understand that I am ultimately responsible for the payment of the charges associated with the testing of this individual to whom I have been exposed, unless an agreement has been worked out between me and my employer, or is otherwise covered by my health care or benefits plan.

18. Signature of Exposed Individual	Date

- "First Responder Provider" is defined as a police officer, fire fighter, or an individual licensed under MCL.333.20950 or 333.20952 as one of the following: medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, or an emergency medical services instructor or coordinator. A lay citizen, or Good Samaritan, if they assist an emergency patient, may also be included as a pre-hospital provider (for purposes of this law).
- "Emergency source patient" means an individual who is transported to an organized emergency department located in and operated by a licensed hospital or a facility other than a hospital that is routinely available for the general care of medical patients.

SECTION 2 – EVALUATION OF EXPOSURE: To be completed by the HEALTH CARE FACILITY.

- **NOTE TO HEALTH CARE FACILITY:**
  If appropriate, testing for Hepatitis C virus should also be considered, although this testing is excluded from this law.

1. Name of Exposed Individual	2. Emergency Source Patient **ID Number**

3. **Based upon the information provided:**

☐ **Exposure DID Occur** *(See item **4** below).* ☐ **Exposure DID NOT Occur** *(See item **5** below).*

4. Exposure DID Occur: The type of exposure was determined to be:

☐ **Open Wound** ☐ **Mucous Membrane** ☐ **Percutaneous** ☐ **Other**

Was the emergency patient informed at the time of admission about the possibility of being tested if a first responder exposure occurred? (In accordance with MCL 333.5133)?

☐ **YES** ☐ **NO**

NOTE: The Exposed Individual **SHOULD BE** counseled and tested for HIV and Hepatitis B. Testing for hepatitis C is also recommended although it is not mentioned in the law. Prophylaxis should also be considered for the exposed individual. If appropriate, please refer the exposed individual for follow-up medical evaluation.

5. Exposure did NOT Occur: Please Explain:

Print Person's Name	Authorized Signature at Health Facility	Date
Job Title		

SECTION 3 – Test Results: To be completed by the HEALTH FACILITY

1. Emergency Patient was Tested for: *(Check all that apply)*

☐ **HIV** ☐ **Hepatitis B** ☐ **Other** (Explain):

2. **TEST RESULTS on Source Individual:**

HIV:	**Rapid Test:**	☐ **Reactive***	☐ **Non-Reactive**	
	EIA:	☐ **Reactive**	☐ **Non-Reactive**	
	Western Blot:	☐ **Reactive**	☐ **Non-Reactive**	☐ **Indeterminate**
Hepatitis B:	**HBsAg:**	☐ **Found**	☐ **Not Found**	

Other (Explain):

3. Emergency Patient **was NOT Tested:** *(Testing Agency: Please Check ALL Reasons Below that Apply)*

☐ **Emergency source patient refused testing / to have blood drawn.**
☐ **Emergency source patient expired before test(s) could be performed.**
☐ **Emergency source patient was released from the health care facility before testing could be performed.**
☐ **Emergency source patient did not present to this facility for care**

Date Test Results were Completed	Date Test Results were Reported Out	Test Results were Mailed to (Name)		
Print Name and Title of Person Providing Test Results		Address Results were mailed to (Number and Street)		
Signature of Person Providing Test Results		City	State	ZIP Code

***HIV Rapid Tests are for screening purposes only. A reactive Rapid Test requires follow-up testing to confirm patient status.**

AUTHORITY: PA 419 of 1994 (M.C.L. 333.20191) **COMPLETION:** Is voluntary, but is required if testing of the source patient is desired.	The Department of Community Health is an equal opportunity employer, services and programs provider.