

INFECTIOUS DISEASE EXPOSURE REPORT FORM

Date and Time of Exposure _____	Place of Exposure _____
EMS Agency _____	Alarm # _____
Exposed Employee Information: Name (last, first): _____ DOB: _____ Home Address: _____ City: _____ State, ZIP: _____ Phone (H): _____ Employer: _____ Phone (W): _____ Employment Category (check one): EMS ___ Fire fighter ___ Law enforcement _____ Other (specify) _____ Any previous exposure? Yes/No If yes, specify disease and date: _____	
Source Reports History of (check as many as apply): HIV/AIDS ___ Hepatitis A ___ B ___ C ___ TB ___ Meningococcal infection ___ Varicella (chickenpox/shingles) ___ Other (specify) _____ Unknown ___	
Source Information (if known): Name (last, first): _____ DOB: _____ Home Address: _____ City: _____ State, ZIP: _____ Phone (H): _____ Race: _____ Gender: M/F Birth Place: _____ Occupation: _____	
Exposure Description 1. What were you in contact with (check as many as apply): Blood ___ Feces ___ Saliva ___ Sputum ___ Cough spray ___ Sweat ___ Tears ___ Urine ___ Vomitus ___ Amniotic fluid ___ Other (describe) _____ 2. What was the method of contact (check as many as apply): ___ Needle stick or sharps ___ Bite ___ Intentional assault ___ Splash by blood or body fluids ___ Blood or body fluids into wound, sore, or rashes that were ___ < 24 h old or ___ > 24 h old ___ Contaminated object (specify) _____ ___ Other (describe specifically) _____ 3. Site of contact (list all body areas exposed): _____ 4. How did the exposure occur? (be specific) _____ 5. Which precautions were followed? _____ Was PPE used at the time of exposure? Yes/No If yes, what? (gloves, Tyvex sleeves, eye protection, mask) 6. What immediate action was taken in response to the exposure to remove the contamination? (e.g., hand washing) (be specific): _____	
Exposed Employee Medical Information Did you seek medical attention? _____ If yes: Date: _____ Time: _____ Place: _____	
To Be Completed by the Medical Facility Name of Facility: _____ Attending Physician: _____ Date/Arrival Time: _____ Testing (check all that apply): ___ Baseline PPD or CXR ___ Acute Hep Panel (HAV/HBV/HCV) ___ HIV ___ RPR Was treatment provided? _____ If yes, specify: _____ Was medication given? _____ If yes, specify: _____ Was medication prescribed? _____ If yes, specify: _____ Follow-up _____	
Employee Signature _____ Date Signed _____ Infection Control Officer/Designee Signature _____ Date Signed _____	
Infection control number (assigned by ME's Office): _____ Copy to Employer, Employee, ME, Risk Manager	