OLD DOMINION EMS ALLIANCE

Old Dominion EMS Alliance

INFECTIOUS DISEASE EXPOSURE REPORT

Please PRINT ALL information using a ballpoint pen

AGENCY NAME:	CASE/ALARM, RUN OR REPORT #:	EXPOSURE DATE:	EXPOSURE TIME:
OTHER AGENCIES ON SCENE/INVOLVED:			
RECEIVING FACILITY:	NAME OF PHYSICIAN/NURSE NOTIFIED:		

EXPOSED PROVIDER INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY, STATE, ZIP:	
PRIMARY PHONE #:	SECONDARY PHONE #:	DATE OF BIRTH:

SOURCE INFORMATION (the person you came in contact with)

SOURCE LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
HOME ADDRESS:	CITY, STATE, ZIP:	
PRIMARY PHONE #:	SECONDARY PHONE #:	

SOCIAL SECURITY NUMBER	DATE OF BIRTH:	GENDER: ❒ M ❒ F ❒ O ❒ UNK	BLOOD SAMPLE TAKEN? ❒ YES ❒ NO ❒ UNK

SOURCE HISTORY: *(check all that apply)* ❒ HIV/AIDS ❒ HEPATITIS A ❒ HEPATITIS B ❒ HEPATITIS C ❒ MENINGOCOCCAL INFECTION ❒ VARICELLA (chicken pox/ shingles) ❒ OTHER *(specify)*:

EXPOSURE DESRIPTION

BRIEF DESCRIPTION OF INCIDENT:

WHAT FLUIDS WERE YOU IN CONTACT WITH? *(check all that apply)*

❒ BLOOD/SERUM ❒ FLUID VISIBLY CONTAMINATED W/BLOOD ❒ CEREBROSPINAL FLUIDS ❒ SYNOVIAL ❒ PERITONEAL
❒ AMNIOTIC FLUID ❒ UTERINE/VAGINAL SECRETIONS ❒ COUGH SPRAY/SPUTUM ❒ SALIVA ❒ FECES
❒ URINE ❒ PLEURAL ❒ VOMIT ❒ SEMEN
❒ OTHER FLUIDS *(describe)*:

WHAT WAS THE METHOD OF TRANSMISSION: *(check all that apply)*

❒ DIRECT CONTACT ❒ INDIRECT CONTACT ❒ LACERATION ❒ NEEDLE STICK ❒ AIRBORNE ❒ BITE ❒ INGESTION
❒ OTHER *(specify):*

LIST ALL BODY AREAS EXPOSED: ❒ EYES ❒ NOSE ❒ MOUTH ❒ OTHER *(specify):*_____
❒ SKIN INTACT ❒ SKIN NON-INTACT ❍ MORE THAN 24HRS ❍ LESS THAN 24HRS OLD

LIST ANY PERSONAL PROTECTIVE EQUIPMENT USED AT TIME OF EXPOSURE: *(check all that apply)* ❒ GLOVES ❒ MASK ❒ GOGGLES
❒ GOWN ❒ TYVEK SUIT ❒ RESPIRATOR ❒ BVM/CPR SHIELD ❒ OTHER *(specify):*

WHAT IMMEDIATE ACTION WAS TAKEN IN RESPONSE TO THE EXPOSURE TO REMOVE THE CONTAMINANT? *(check all that apply)*
❒ WASHED THE AREA ❒ FLUSHED THE AREA ❒ OTHER *(specify):*

ESTIMATED TOTAL DURATION OF EXPOSURE: HOURS: MINUTES:

I HEREBY REQUEST THAT THE ALL APPROPRIATE SOURCE TESTING BE COMPLETED FOR THE PURPOSE OF IDENTIFYING ANY POTENTIAL PATHOGEN EXPOSURE. I RECOGNIZE THAT SHOULD THE SOURCE NO LONGER BE VIABLE, I MAY REQUIRE FURTHER TESTING. I HEREBY AFFIRM THAT THE FACTS STATED IN THIS DOCUMENT ARE TRUE.

PROVIDER'S SIGNATURE: X_____ DATE: _____/_____/_____

PROVIDER	**SOURCE**
PROVIDER STICKER HERE	SOURCE STICKER HERE

HOSPTIAL USE ONLY (to be completed by the hospital's Infection Control Practitioner)

CP FOLLOW-UP COMPLETED BY:

ICP SIGNATURE: X_____ DATE: _____/_____/_____

(Medical Facility will forward copies as REQUIRED) *Rev. 04/2018 jrs*

White – Hospital Copy **Yellow – Provider Copy** **Pink – Agency OMD Copy** **Gold – ODEMSA Copy**