Infectious Exposure Form

Exposed Member's Name: ______________________________ Position: ___________________

Soc. Sec. #: ______________________________ Home Phone: ________________

Field Inc. #: _________________ Shift: ___________ Company: ______________________

Name of Patient: ____ Sex: ___________

Age: _________ Address: ____

Suspected or Confirmed Disease: ____

Transported to: ____

Transported by: ____

Date of Exposure: ____________________________ Time of Exposure: ______________

Type of Incident (auto accident, trauma): _______________________________________

Type of protective equipment utilized: ____

What where you exposed to:

Blood ______ Tears ______ Feces ______ Urine ______ Saliva ______

Vomitus _______ Sputum _______ Sweat _______ Other _______

What part(s) of your body became exposed? Be specific: ______________________________

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Did you have any open cuts, sores, or rashes that became exposed? Be specific: ______________

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How did exposure occur? Be specific: ____

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Did you seek medical attention? _______Yes _______No

Where? ____________________________________ Date: ______________________

Contact Infection Control Supervisor: Date_________________ Time: ______________________

Supervisor's Signature: ___________________________ Date: ______________________

Member's Signature: _____________________________ Date: ______________________

Infection Control Supervisor's Report

Medical facility notified? Yes _______ No ________

If Yes:

Name of Facility: ____ Date: ______________________

Address of Facility: ____

Name of Facility Contact: ____

Confirmed Exposure: ____

Member notified? Yes ________ No ________

Member's Signature: ____ Date: ______________________

Medical Follow-Up Action:

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Remarks:

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Infection Control Supervisor's Signature: _____________________________ Date: ______________________