



## Exposure Report Form - Blood or body fluid

*(To be completed by emergency worker at the time of incident)*

### **Exposed Employee Information:**

Name:		
SSN:	Phone (h):	Rank:
Address:		
City:	State:	Zip:

### **Incident Information:**

Incident Number:	District:
Incident Location:	Type of incident:

### **Exposure Description:**

Date of Exposure:	Time of Exposure:
What body fluid(s) were you in contact with? <input type="checkbox"/> Blood <input type="checkbox"/> Feces <input type="checkbox"/> Saliva <input type="checkbox"/> Sputum <input type="checkbox"/> Sweat <input type="checkbox"/> Tears <input type="checkbox"/> Urine <input type="checkbox"/> Vomitus <input type="checkbox"/> Other (describe specifically):	
What was the method of contact? <input type="checkbox"/> Exposure with contaminated sharps (i.e.: needle, scalpel, glass, etc.) Type of needle & depth _____ <input type="checkbox"/> Blood or body fluids into natural body openings (e.g. nose, mouth, eye) <input type="checkbox"/> Blood or body fluids into cut, wound, sores, or rashes less than 24 hours old Please specify: _____ <input type="checkbox"/> Blood or body fluids on intact skin <input type="checkbox"/> Other (describe specifically):	
How did the exposure occur? Be specific.	
What action was taken in response to the exposure to remove the contamination (e.g. hand washing?)	
What personal protective equipment was being used at the time of exposure?	
Describe any other information related to the incident. Task being performed at time of exposure, etc.:	

### **Source of Exposure:**

Name of Patient:	Sex
Receiving Health Care Facility:	
Transported by:	
Patients Physician:	

**Medical Information**

Did you seek medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
If yes, where?	
Did you contact the Infection Control Coordinator? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date & time:	
Name of Infection Control Coordinator:	

\_\_\_\_\_  
Incident Commander Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Infection Control Coordinator Signature

\_\_\_\_\_  
Date

**To be completed by the Infection Officer:**

Post Exposure follow-up needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of follow up:
Doctor:	
Comments:	

***Report to be maintained  
for 30 years after employment separation***