County Of Louisa
Department of Fire and EMS
Infectious Disease Exposure Report

Please print all information using black/blue ink Date:_____

Provider Name:_____ Agency:_____

Contact Phone:_____ Other Agency involved:_____

Date of Incident:_____ Time of Incident:_____ PPCR #_____

Patients Name:_____ SS#_____

Patient D.O.B.:_____ PT Blood Drawn?___Yes ___No ____UNK

Receiving Hospital:_____ Arrival Time:_____

Name of Physician/Nurse Notified:_____

Brief Description of Incident:_____
_____
_____
_____

Source of Exposure:

___Saliva	___Vomitus	___Respiratory Secretions
___Blood	___Pus	___Rash
___Urine	___Feces	___Other

Type of Exposure: _____ Location on Providers' body:_____

A.____Skin
- ___Intact
- ___Not intact (i.e., open area, excema, abrasion, etc.)

B.____Percutaneous
- ___Puncture
- ___Laceration
- ___Bite

C.___Mucous Membrane
- ___eye
- ___Mouth
- ___Nares

D. ___Clothing
- ____Soaked
- ____Droplets
- ____Diluted
- ____Dried

E.___Airborne
- ___Spitting
- ___Coughing
- ___Vomiting
- ___Talking
- ___Intubation
- ___Suctioning
- ___Mouth to Mouth (unshielded)

(**Note**: If blood soaked through clothing, mark "A" and complete accordingly.)

Duration of exposure:_____ (total time)

Personal Protective Equipment Used: ___Mask/Shield combo ___Mask(surgical) ___Mask (N95)
___Gloves ___Gown ___Respirator
___Tyvek suit ___Resuscitation shield

Steps Taken to minimize exposure: ___washed skin ___irrigated eyes ___rinsed mouth
___Masked Patient ___Changed clothing ___Other

I authorize any necessary testing of my person on behalf of the provider listed.

Patient (Print):_____

Patient Signature:_____ Date:_____

I request that appropriate tests be conducted on the above patient on my behalf.

Provider Signature:_____ Date:_____

The above signatures witnessed by:

Print Name:_____ Title:_____

Signature of witness:_____ Date:_____

Completed by:_____Date:_____

Reviewed By (Phyician):_____Date:_____

Disposition:

Patient results:_____ Date Provider Notified:_____

Provider Follow-up needed:_____