County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

COMMUNICABLE DISEASE EXPOSURE REPORTING FORM

PREHOSPITAL AGENCY REPORTING INFORMATION (SECTION 1)

Date of Report _____ Date of Incident _____ Time of Incident_____
Transporting Agency _____ Unit Number _____ Full CAD Incident # _____

Personnel Exposed	Agency Name	Signature	Post Results Date/Time
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name of Nurse Receiving Patient Turnover _____
Name of Agency Supervisor or Company Officer Notified _____
Phone Number of Above _____
Name of Agency Designated Infection Control Officer (DICO) _____
Phone Number of Above _____

Type of Exposure (Check all that apply)
Airborne (e.g. Measles, TB) ☐ Droplet (e.g. Meningococcal Meningitis) ☐
Bloodborne (e.g. Needlestick, Splash) ☐ Other (explain below) ☐
Other explanation _____

Nature of Exposure (Check all that apply)
Needlestick ☐ Puncture ☐ Laceration ☐ Splash ☐ Mouth to Mouth ☐ Other (explain) ☐
Other explanation _____

What were you exposed to? (Check all that apply)
Blood ☐ Emesis ☐ Feces ☐ Urine ☐ Sputum ☐ Body Fluids ☐ Wound ☐ Other (explain) ☐
Other explanation _____

How did the exposure occur? - Provide a clear concise description of the exposure

_____
_____
_____
_____
Receiving Hospital _____ Source Patient Name_____

SOURCE PATIENT & FACIILTY INFORMATION (SECTION 2)

Source Patient DOB_____ Source Patient Medical Record Number _____
Name of Charge Nurse, MICN or BHNC that received completed form _____
Phone number for person listed above _____
Name of Hospital Infection Control Officer _____
Phone Number of Hospital Infection Control Officer _____

FOLLOW UP ACTIONS AND COMMUNICATION BY HOSPITAL PERSONNEL
(SECTION 3)
*****HOSPITAL USE ONLY*****

Receiving Hospital _____ Source Patient Name_____

Action Taken	**By Whom**	**Date/Time**	**Results**
Lab work ordered on Source Patient	Name		
_____	_____	_____	_____
_____			
HOSPITAL Infection Control Officer notified? Yes ◯ No ◯	_____	_____	_____
Treatment Offered Yes ◯ No ◯	_____	_____	_____
If yes, describe treatment here			
_____			
_____			
_____			
Referred to Provider? Yes ◯ No ◯	_____	_____	_____
If yes, list provider here _____			
AGENCY Infection Control Officer notified? Yes ◯ No ◯	_____	_____	_____
If yes, name specifically who was notified _____			
Determined NOT to be an exposure Yes ◯ No ◯	_____	_____	_____
Suspected or Known Disease Exposure Yes ◯ No ◯	_____	_____	_____
If yes, enter details here			
_____			
_____			
_____			

Describe how this information was obtained (e.g. CXR, Lab Confirmation, Reported by family, other)

_____
_____

INSTRUCTIONS FOR PREHOSPITAL PROVIDERS & RECEIVING HOSPITALS

Instructions for Prehospital Providers

Complete sections 1 & 2 and make 3 copies
- Copy 1- Charge Nurse/MICN/BHNC
- Copy 2- Agency Supervisor/Company Officer/DICO
- Copy 3- Exposed Provider

Instructions for Receiving Hospitals

Complete section 3
Document notification of hospital DICO
Document notification of agency DICO
Document lab test ordered
Document lab test results
Document treatment offered to Provider