**Pre-hospital Uniform Communicable Disease Exposure Report**

### Instructions
1. Complete sections 1 - 6 located in the upper portion of this form according to instructions found in the Infection Control Binder.
2. The Pink copy is separated and forwarded to the Service's Infection Control Officer and the top two copies are given to the EMS Coordinator/Hospital Contact Person.

### 1. Personnel Information
- **Name:**
- **Your Telephone No.:**
- **Service:**
- **Infection Control Officer:**
- **Service's Telephone No.:**

### 2. Exposure Information
- **Date of Incident:**
- **Time of Incident:**
- **Location of Incident:**
- **Patient's Name:**
- **Age/Sex:**
- **Receiving Hospital:**
- **Patient had:**
  - Cough
  - Fever
  - Body rash
  - Jaundice
  - Other:

### 3. Type of Exposure
- Airborne
- Definite Parenteral Exposure
- Possible Parenteral Exposure
- Doubtful Parenteral Exposure
- Contaminated needlestick
- Non-contaminated needlestick
- Laceration or similar bleeding wound caused by a contaminated object/instrument
- Laceration or similar fresh wound exposed to blood/body fluid
- Non-bleeding wound produced by blood/body fluid contaminated instrument
- Splash of blood or other potentially infectious material into eyes, mucus membranes
- Extensive exposure with open wounds, dermatitis or chapped skin
- Mouth-to-mouth resuscitation without a pocket mask or one-way valve
- Other exposure that may be significant
- Other:

* See definitions in detailed instructions.

### 4. Personnel Protective Equipment
Personnel Protective Equipment in use at the time of exposure:
- None
- Gloves
- Goggles
- Face Shield
- Mask
- Hepa Mask
- Gown/Jumpsuit
- Other:

- I have completed the Hepatitis B Vaccine Series

### 5. Description of Exposure
Describe the incident and circumstances under which the exposure occurred in detail.

### 6. Post Exposure Measures Taken
- Saline Irrigation
- Handwashing
- PPD Done
- Rifampin
- Title - Measles
- Title - Chicken Pox
- Title - Rubella
- Other:

Were you seen, evaluated and/or treated at a medical facility following this exposure?
- Yes
- No

If yes, name of facility:

Name of provider:

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**Findings/Recommendation(s):**
- Information provided was insufficient to determine exposure risks
- No further action required, exposure not significant or patient is negative for communicable disease
- Actions taken already are adequate
- Medical evaluation/follow-up required/recommended
  - Hemophils Influenza
  - Rubella
  - Hepatitis
  - Tuberculosis
  - HIV
  - Measles
  - Varicella (Chicken Pox)
  - Other: Meriogococcal

**Comments:**

**Notification(s):**
- Date
- Time
- Contact
- Method
- Initials

Date follow-up sent to service:

Completed by:

Name:

Telephone Number: