

The EXPOSED individual must complete sections 1-3. Section 4 is to be completed by the treating facility's Emergency Department personnel. Please print legibly.

<i><b>Patient Information</b></i>		<i><b>Section 1</b></i>
Date	Run Report #	Medical Record #
Patient transported to:		

<i><b>Prehospital Provider Information</b></i>	<i><b>Section 2</b></i>
Exposed Person's Name	
Exposed Person's Employer's Name:	
Check Agency Type: <input type="checkbox"/> EMS Agency <input type="checkbox"/> Fire Department <input type="checkbox"/> Police Department	

<i><b>Description of Exposure Incident</b></i>				<i><b>Section 3</b></i>
Exposure Route	Type of Body Fluid			Barriers Used
Needle Stick	Amniotic Fluid	Peritoneal Fluid		Gloves
Bite with Broken Skin	Blood	Pleural Fluid		Mask
Mucosal	Breast Milk	Saliva		Goggles
Skin: Abraded or Lacerated	Cerebrospinal Fluid	Semen		Gown
	Pericardial Fluid	Vaginal Secretions		None Used
Other circumstances surrounding incident:				

<i><b>To Be Completed by Hospital</b></i>			<i><b>Section 4</b></i>
Was Source Testing Done?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Completed:	
Name of Emergency Department Physician Treating Patient?			
Recommended Follow-Up:	<input type="checkbox"/> None Indicated	<input type="checkbox"/> As Directed Below:	

**CQI Communicable Disease Exposure Form**
