## BLACK OUT EMERGENCY MEDICAL CARE PROVIDER & SOURCE INFO PRIOR TO SUBMITTING TO OEMS

## DELEASE AREA Diferent Terretoria Medical Control Different Medical Control Different Medical Control Different Medical Control

## **REPORT OF POTENTIAL EXPOSURE FORM EMERGENCY MEDICAL CARE PROVIDER**

\*\*All fields must be completed\*\*

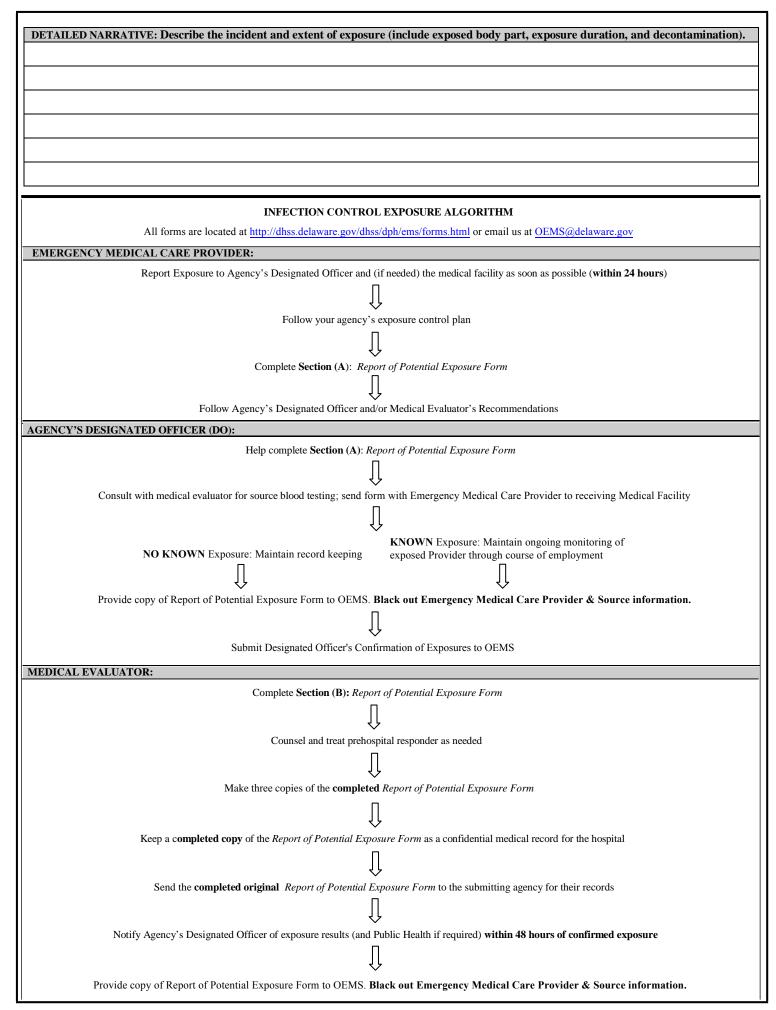
SECTION A: TO BE COMPLETED BY THE EMERGENCY MEDICAL CARE PROVIDER WITH ASSISTANCE FROM THE AGENCY'S DO (PLEASE PRINT)						
Submitting Agency:	Submitting Agency's Phone #:					
Submitting Agency's Designated Officer (DO) Name:	Designated Officer's (DO) Phone #:					
Submitting Agency's Address:						
Emergency Medical Care Provider's Name:	Emergency Medical Care Provider's Phone #:					
Source Patient's Name:	Source Patient's DOB:					
Location of Incident:	Incident #:					
Date of Exposure:	Time of Exposure (24 hr):					
Source Patient Transported To:	Date Form Submitted:					

## What was the Exposure Route?

Inhalation Ingestion Injection Direct Contact	Coughing Splash/Spray Medical Sharp Broken Skin	Sneezing Hand-to-Mouth Cont Hollow-bore Needle Non Broken Skin (du	tact Mouth-to Bite		) Dther Dther
Body Fluid Exposure:	Blood Respiratory Secretion	Urine Is Saliva	Feces Vomit	Sweat Other	Amniotic Fluid
Personal Protective Equipment () Did PPE fail? YES NO	,	None Gloves	Eye Protection Gown	HEPA Mask (N95 or b Turnout Gear	etter) Surgical Mask Other
Did vou Receive Medical Attenti	on? YES	NO If YES, Whe	ere:	]	Date:

\*\*\* DESCRIBE THE INCIDENT AND EXTENT OF THE EXPOSURE ON THE BACKSIDE OF THIS PAPER. (BE DETAILED) \*\*\*

Emergency Medical Care Provider's Signature			Agency's Designated Officer Signature					
SECTION B: TO BE COMP	LETED BY TH	HE RECE	IVING M	IEDICAL I	FACILITY (PL	EASE PRINT)		
Facility Name:					Health Care Provider's Name:			
Phone #:					Facility's Designated Officers Name:			
Source Patient								
Source has NO known infectious disease. Source has				e has known in	fectious disease.	Source pa	tient NOT tested	
Confirmed medical rec	cord/test		Confirmed medical record/test					
Emergency Medical Care P	Provider:							
Post exposure Prophylaxis Ind	icated?	YES	NO	If YES, T	reatment Given:		Fol	llow up neccessary
The Emergency Medical Ca	are Provider has	s been info	rmed of th	he results of	the evaluation fo	or exposure to bloodbo	rne, airborne, and/or potentially	infectious material
Notification made by:	Phone		Mail		Email	Fax	Other	
Caller's Name:					Date		Time (24 hr):	
The Emergency Medical other potentially infection						•	re to bloodborne, airborne, a	nd/or
Facility Notes:								
HealthCar	re Provider's S	ignature					Title	



Additional Information may be found in Delaware Law under Title 16 Chapter 12A, Notification of Emergency Medical Providers of Persons with Communicable