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

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……	☐ Coughing	☐ Sneezing	☐ Confined proximity (duration:_____)	
Ingestion……	☐ Splash/Spray	☐ Hand-to-Mouth Contact	☐ Mouth-to-Mouth Contact	☐ Other _____
Injection……....	☐ Medical Sharp	☐ Hollow-bore Needle	☐ Bite	☐ Other _____
Direct Contact……..	☐ Broken Skin	☐ Non Broken Skin (duration):_____		

Body Fluid Exposure: ☐ Blood ☐ Urine ☐ Feces ☐ Sweat ☐ Amniotic Fluid
☐ Respiratory Secretions ☐ Saliva ☐ Vomit ☐ Other _____

Personal Protective Equipment (PPE) Used: ☐ None ☐ Eye Protection ☐ HEPA Mask (N95 or better) ☐ Surgical Mask
☐ Gloves ☐ Gown ☐ Turnout Gear ☐ Other_____
Did PPE fail? ☐ YES ☐ NO

Did you Receive Medical Attention? ☐ YES ☐ NO If YES, Where: _____ 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 COMPLETED BY THE RECEIVING MEDICAL FACILITY (PLEASE PRINT)	
Facility Name:	Health Care Provider's Name:
Phone #:	Facility's Designated Officers Name:

Source Patient

☐ **Source has NO known infectious disease.**
☐ Confirmed medical record/test

☐ **Source has known infectious disease.**
☐ Confirmed medical record/test

☐ **Source patient NOT tested**

Emergency Medical Care Provider:

Post exposure Prophylaxis Indicated? ☐ YES ☐ NO If YES, Treatment Given:_____ ☐ Follow up neccessary

☐ **The Emergency Medical Care Provider has been informed of the results of the evaluation for exposure to bloodborne, airborne, and/or potentially infectious materials.**

Notification made by: ☐ Phone ☐ Mail ☐ Email ☐ Fax ☐ Other _____

Caller's Name: _____ Date:_____ Time (24 hr):_____

☐ **The Emergency Medical Care Provider has been told about health conditions that could result from exposure to bloodborne, airborne, and/or other potentially infectious materials which require further evaulation, follow up and/or treatment.**

Facility Notes:

_____
_____
_____
_____
_____
_____

_____ _____
HealthCare Provider's Signature **Title**

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL 10/2018

DETAILED NARRATIVE: Describe the incident and extent of exposure (include exposed body part, exposure duration, and decontamination).

INFECTION CONTROL EXPOSURE ALGORITHM

All forms are located at http://dhss.delaware.gov/dhss/dph/ems/forms.html or email us at OEMS@delaware.gov

EMERGENCY MEDICAL CARE PROVIDER:

Report Exposure to Agency's Designated Officer and (if needed) the medical facility as soon as possible (**within 24 hours**)

⇩

Follow your agency's exposure control plan

⇩

Complete **Section (A)**: *Report of Potential Exposure Form*

⇩

Follow Agency's Designated Officer and/or Medical Evaluator's Recommendations

AGENCY'S DESIGNATED OFFICER (DO):

Help complete **Section (A)**: *Report of Potential Exposure Form*

⇩

Consult with medical evaluator for source blood testing; send form with Emergency Medical Care Provider to receiving Medical Facility

⇩

NO KNOWN Exposure: Maintain record keeping

⇩

KNOWN Exposure: Maintain ongoing monitoring of exposed Provider through course of employment

⇩

Provide copy of Report of Potential Exposure Form to OEMS. **Black out Emergency Medical Care Provider & Source information.**

⇩

Submit Designated Officer's Confirmation of Exposures to OEMS

MEDICAL EVALUATOR:

Complete **Section (B):** *Report of Potential Exposure Form*

⇩

Counsel and treat prehospital responder as needed

⇩

Make three copies of the **completed** *Report of Potential Exposure Form*

⇩

Keep a c**ompleted copy** of the *Report of Potential Exposure Form* as a confidential medical record for the hospital

⇩

Send the **completed original** *Report of Potential Exposure Form* to the submitting agency for their records

⇩

Notify Agency's Designated Officer of exposure results (and Public Health if required) **within 48 hours of confirmed exposure**

⇩

Provide copy of Report of Potential Exposure Form to OEMS. **Black out Emergency Medical Care Provider & Source information.**