



# 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
Did PPE fail? YES NO	Gloves	Gown	Turnout Gear
			Other _____

**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
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**Emergency Medical Care Provider:**

**Post exposure Prophylaxis Indicated?** YES NO If YES, Treatment Given: \_\_\_\_\_ Follow up necessary

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 evaluation, follow up and/or treatment.

**Facility Notes:**

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\_\_\_\_\_  
 HealthCare Provider's Signature Title

**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@state.de.us](mailto:OEMS@state.de.us)

**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 **completed 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.**