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

## REPORT OF POTENTIAL EXPOSURE FORM

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

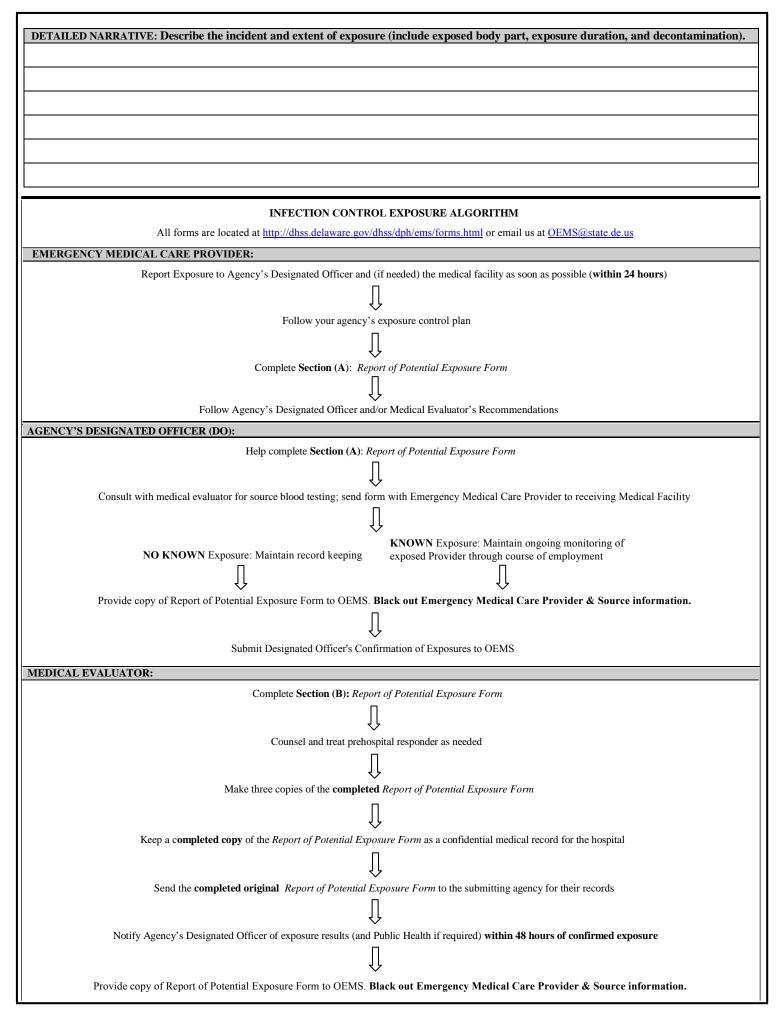
SECTION A: TO BE COMPLETED BY THE EMERGENCY MEDICAL CARE PROVIDER WITH ASSISTANCE FROM THE AGENCY'S DO (PLEASE PRINT)					
Submitting Agency:	Submitting Agency's Phone #:				
Submitting Agency's Designated Officer (DO) Name:	Designated Officer's (DO) Phone #:				
Submitting Agency's Address:					
Emergency 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 Con Hollow-bore Needle Non Broken Skin (d	tact Mouth-to Bite		Other) Other
Body Fluid Exposure:	Blood Respiratory Secretion	Urine Is Saliva	Feces Vomit	Sweat Other	Amniotic Fluid
Personal Protective Equipment (I Did PPE fail? YES NO	<i>,</i>	None Gloves	Eye Protection Gown	HEPA Mask (N95 or b Turnout Gear	better) Surgical Mask Other
Did vou Receive Medical Attenti	on? YES	NO If YES. Wh	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 COMPL	LETED BY THE REG	CEIVING MEI	DICAL FACILITY (PLF	EASE PRINT)			
acility Name:			Health Care Prov	vider's Name:			
Phone #:			Facility's Design				
ource Patient			,				
Source has NO known infe	ctious disease.		Source has known infe	ectious disease.	Source patient NOT tested		
Confirmed medical rec	cord/test	Confirmed medical record/test					
mergency Medical Care P	rovider:						
ost exposure Prophylaxis Indi	icated? YES	NO If	f YES, Treatment Given:		Follow up neccessary		
The Emergency Medical Ca	are Provider has been i	nformed of the r	esults of the evaluation for	r exposure to bloodbor	rne, airborne, and/or potentially infectious materia		
Notification made by:	Phone	Mail	Email	Fax	Other		
Caller's Name:			Date:		Time (24 hr):		
The Emergency Medical C other potentially infectiou Facility Notes:				-	re to bloodborne, airborne, and/or		
Facility Potes.							
HealthCar	re Provider's Signatur	e			Title		
HealthCar	e Provider's Signatur	e					



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