Rappahannock Emergency Medical Services Council, Inc.

AGENCY: _____

REPORT OF OCCUPATIONAL EXPOSURE

CONFIDENTIAL

Part I: Patient Information			
Name (Last, First, MI):			
Sex:	Age:	Patient Account #:	Patient History #:

Part II: Exposure Information
A. Exposed to: Blood☐ Saliva☐ Tears☐ Emesis☐ Feces☐ Sputum☐ Urine☐ Other(specify)☐
B. Route of exposure: Percutaneous☐ Mucous Membranes☐ Open Skin(cut, etc.)☐ Dermatitis☐ Other(specify)☐
C. Area exposed: Hand/Finger☐ Nose/Mouth☐ Face☐ Eye☐ Arm☐ Leg☐ Torso☐ Other(specify)☐
D. Visible blood on device or in fluid? Yes☐ No☐
E. Amount of blood/body fluid exposed to: Minor☐ Moderate☐ Major☐
F. How deep was the injury? Superficial(scratch)☐ 0.25cm☐ 0.5cm☐ Deep☐
G. Type of device: IV /Hollow-bore needle☐ Butterfly☐ Scalpel☐ Lancet☐ Knife blade☐ Other(specify) ☐ N/A☐
H. Was the needle in an artery or vein? Yes☐ No☐ N/A☐
I. PPE used: Uniform☐ Gown☐ Eye Protection☐ Firefighting protective equipment☐ Patient Care Gloves☐ Mask☐ Leather/Extrication Gloves☐ Other(specify) ☐
J. Procedure being performed: Hemorrhage Control☐ IV/Medication Administration☐ Sharps Disposal☐ Finger Stick Airway Management☐ Decontamination☐ Passing Instrument☐ Other(specify)☐

Part III: Employee Information	
Name (Last, First, MI):	Rank:
Social Security #:	Employee dept. unit #:
Phone (Home/Work):	E-mail address:
Assigned stat./shift:	Incident #:
Exposure date:	Exposure time:
Receiving facility of patient:	Patient's receiving facility room #:
Receiving nurse/physician:	Employee's receiving facility Hx #:

Part IV: Initial Reporting Process (MUST BE DONE IMMEDIATELY)	
Dept. designated officer:	Date/Time notified:
Inf. control officer notified:	Date/Time notified:
Return report received:	Date/Time/by whom:
Follow-up needed:	Recommended Date/Time:

Part V: Post Exposure Follow-Up	
Employee notified by:	Date/Time notified:
Appointment scheduled by:	Date/Time of appointment:
Name of physician contacted:	Date/Time notified:
Physician's facility:	Physician's/facility's contact #:

Part VI: Case Closed/Filed	
By whom:	Date/Time:

A statement provided by the employee documenting the exposure and how it occurred must be attached to this form. This statement must be completed as soon as possible or within 24 hours to ensure that the department provides the employee with the appropriate care and counseling.