

SPOKANE COUNTY EMS *POTENTIAL* INFECTIOUS DISEASE EXPOSURE FORM

1. SECTION TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

SUBMITTING AGENCY	AGENCY INCIDENT RUN #	DATE OF OCCURENCE	TIME OF OCCURENCE
EMPLOYEE NAME, -LAST	FIRST	MIDDLE	IDENTIFICATION NUMBER
DATE OF EXPOSURE	TIME OF EXPOSURE	LOCATION OF INCIDENT	LEOFF I OR LEOFF II
<input type="checkbox"/> REPORT ONLY	<input type="checkbox"/> RECEIVED FIRST-AID	<input type="checkbox"/> VISITED ER / PHYSICIAN	<input type="checkbox"/> HOSPITALIZATION

Exposure Type: Human Animal (Species: _____) Other (e.g., sewage) _____

Body Fluid Exposure To (* - Circle if visibly contaminated with blood):
 Blood Vomit* Saliva* Urine* Feces* Sweat* Respiratory Secretions
 Other* _____

What was the Exposure Route?
 INHALATION Coughing Sneezing Confined proximity (duration: _____)
 INGESTION..... Splash / Spray Hand-to-mouth contact
 PERCUTANEOUS Hollow-bore Needle Solid Needle Medical Sharp Other Sharp Bite
 MUCOCUTANEOUS... Nasal Oral Ocular Uro-Genital/Anal
 CUTANEOUS..... Non-intact Skin Intact Skin but Large Fluid Volume

What part of the body was exposed?: _____

Describe the extent of exposure (include exposure duration and decontamination): _____

Describe the procedure / activity being performed at the time of exposure: _____

What personal protective equipment (PPE) was in use at the time of exposure?: _____

Describe the medical device being used, including type and brand: _____

Describe controls or work practices in use at the time of the exposure: _____

Suggested training or condition changes that would prevent a recurrence: _____

EMPLOYEE SIGNATURE

2. SECTION TO BE COMPLETED BY MEDICAL EVALUATOR / MD (PLEASE PRINT)

HEALTH CARE PROVIDER	PROVIDER'S LOCATION	PROVIDER'S NAME	PHONE NUMBER
<input type="checkbox"/> NON-SIGNIFICANT EXPOSURE	<input type="checkbox"/> SIGNIFICANT EXPOSURE (complete the section 3 below)	EVALUATION DATE	EVALUATION TIME

Post-Exposure Prophylaxis Indicated Post-Exposure Prophylaxis Not Indicated

The employee named above has been informed of the results of the evaluation for exposure to blood and/or other potentially infectious materials.

The employee named above has been told about health conditions that could result from exposure to blood or other potentially infectious materials which require further evaluation, follow-up and/or treatment.

A follow-up appointment(s) is required [location(s), date(s) & time(s)]: _____

SOURCE INFORMATION:
 Source has known or probable infectious disease Voluntary Consent Testing initiated
 Court ordered compelled testing Spokane Regional Health District contacted for compelled testing

HEALTHCARE PROVIDER SIGNATURE / TITLE

3. HOSPITAL INFECTION CONTROL

Hospital infection control investigation completed Spokane Regional Health District Contacted (when appropriate)

Other Responding Agencies Notified _____
 (See HIPAA warning on back of this form)

SIGNATURE / TITLE

4. AGENCY FORMAL REVIEW PROCESS (SIGNATURES REQUIRED)

Information transferred onto Needlestick Log Corrective action implemented, as warranted

SUPERVISOR NAME & BADGE #	DATE	PHONE	COMMENTS
SHIFT OR UNIT SUPERVISOR	DATE	PHONE	COMMENTS
AGENCY DIRECTOR	DATE	PHONE	COMMENTS

POTENTIAL INFECTIOUS DISEASE EXPOSURE ALGORITHM

EMPLOYEE:

Significant Exposure

↓
Complete Section (1) of the *Spokane County EMS Potential Infectious Disease Exposure Form*
↓
Report to Designated Medical Facility for Treatment (Within Two Hours)
↓
Follow MD, PA, or NP's Recommendations
↓
If Diagnosed as a Significant Exposure, Consult with MD for Source Blood Testing
↓
Return Top Copy of Form to Your Agency - Following Agency Protocol
↓
Keep Back Copy of Form for Your Records
☒

MEDICAL EVALUATOR/MD:

Please Complete Section (2)
↓
If Significant Exposure is Determined, Answer All Questions
↓
Counsel as Required
↓
For Significant Exposure and Compelled Testing or Court Ordered Testing:
Contact the Spokane Regional Health District at **(509) 324-1542**

Mandatory testing for HIV may be attainable under WAC 296-823-16010 or RCW 70.24.340(4) for employees who have experienced a substantial exposure to another person's body fluid(s) in the course of employment.

↓
Have Employee Return Top Copy to Employer
↓
Make a Photo Copy for Hospital Infectious Disease Control Manager
↓
Return Back Copy to Employee

HOSPITAL INFECTION CONTROL:

If There Is A Significant Exposure, Complete Section (3)
↓
Complete Hospital Infection Control Investigation According to Hospital Protocol
↓
Notify the Spokane Regional Health District if Required
↓

HIPAA WARNING

**Do not share personal identification information with other agencies.
Do not copy, reproduce, or share this form – Personal information is protected under the
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996,
PUBLIC LAW 104-191 - HIPAA**

↓
Do Inform Other Agencies Who Responded To Run About Exposure Potential, If Known
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Keep This Form as a Confidential Medical Record
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AGENCY FORMAL REVIEW PROCESS:

Transfer Information as Required onto the Needlestick Log WAC 296-823
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If a Training or Condition Change Would Prevent Reoccurrence of Exposure Implement
Corrective Action
↓
Follow Protocols for Handling Agency Forms
Forward a Copy of Form to Workers' Compensation, Safety and / or Risk Management,
As Required.
↓
Complete Formal Review Process and File as Confidential Medical Record
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