Pre-Hospital Post Exposure Work Sheet

Section 1 - Agency Information

(To be completed by DICO)

Agency Name: _____ Date of Exposure: ___/____/____ Time of Exposure: ___/____/____

Billing address of agency: _____, _____, _____
Street Address City Zip

Incident #: _____ Name of Agency's DICO: _____

Name of Exposed Employee: _____, DOB: ____/____/____

Name of Source Patient: _____, DOB: ____/____/____

Section 2 - Initial Determination

(To be completed by DICO)

Type of body fluid: ☐ Blood ☐ Semen ☐ Vaginal or amniotic fluids ☐ Breast milk ☐ CSF ☐ Pericardial Fluid ☐ Peritoneal Fluid ☐ Pleural Fluid ☐ Synovial Fluid

* Saliva, vomitus, urine, feces, sweat, tears and respiratory secretions are only considered infectious if they contain **visible** blood.
* Bites are considered an exposure only if blood was present in the mouth of the biter before the bite. If saliva is non-bloody, there is no risk of exposure to HIV. However, there is a negligible risk of transmission of HBV & HCV.

Type of exposure: ☐ Percutaneous ☐ Mucous Membrane (eyes, nose, mouth) ☐ Non-intact Skin

Brief description of exposure: _____

_____

_____

Section 3 - Form of Request

(To be completed by DICO)

After reviewing the above facts, I have determined that the above named employee may have been exposed to an infectious disease. Therefore, as the agency's DICO, I am requesting that the Emergency Room Physician of the receiving medical facility make a determination as to whether the above named employee has been exposed to a listed infectious disease based on the facts noted above.

_____ _____
Signature of Agency's Designated Infection Control Officer Date

Section 4 - Evaluation & Response to Form of Request

(To be completed by Emergency Room Physician)

Name of Physician: _____, Date: ____/____/____

Name of Treating Facility or Facility Determining the Cause of Death: _____

I have reviewed the facts noted above regarding a possible exposure to a listed infectious disease. After review, I have made the following determination.

☐ The above named employee has been exposed to a listed infectious disease.
☐ The above named employee has not been exposed to a listed infectious disease.
☐ The facts are insufficient to make a determination or the treating facility possesses no information on the source patient.

It has been determined that the above named employee has had an exposure to a listed infectious disease. I have consulted with Dr. an Infectious Disease Specialist or the National Clinicians' PEP Hotline at: 1-888- 448-4911, regarding post exposure prophylaxis.

_____ _____
Physicians Signature Date

(Once this form is completed, both the hospital and prehospital agencies should receive a copy for their records)