Southern Fox Valley EMS System
EXPOSURE REPORT

TO BE COMPLETED BY INVOLVED EMPLOYEE

Date of Report: _____ Employer and Department:_____

Time of Report:_____

Employee's Name:_____

Employee's Address: _____

Social Security Number: _____

Employee's Telephone: _____

Treatment Received at: _____

Date of Incident: _____ Time of Incident: _____

Have you received the Hepatitis B Vaccine: Yes No When: _____

Did you complete the series (3 doses) Yes No

Blood or Body Fluid that was involved: (circle all the apply)

Blood Emesis Feces Saliva Sputum Tears Urine

Other: _____

Explain Exposure: include what parts of your body were involved, how it happened, and if any rashes or open cuts, sores etc. were present. Also explain what Personal Protection Devices were used.

_____

_____

_____

_____

_____

_____

Patient's Name and Date of Birth: _____

Employee's Signature_____

Date: _____

TO BE COMPLETED BY TREATING STAFF

Physicians Evaluation: (please check one)

_____ Non-infectious, non-penetrating wound. Requires no follow up.

_____ Potentially infectious: requires further follow up
Recommend that Employee and Patient be drawn for HIV and Hepatitis B.
Results should be given to the employee by the EMS office when they are available.

Emergency Physicians Signature: _____ Date: _____

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Patient's Blood Test:

Test	Date Drawn	Results & Date Received
HIV Serology	_____	_____
HBsAB	_____	_____

Employees Blood Test:

Test	Date Drawn	Results & Date Received
HIV Serology	_____	_____
HBsAB	_____	_____

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Treatment Provided: (Circle all that apply)

Wound Care Sutures Irrigation Admitted

Instructions for Follow Up Given

Perscriptions Written for:_____

Other: _____

Treating Nurse Signature: _____ Date:_____

AFTER THIS FORM HAS BEEN COMPLETED

PLEASE FORWARD TO THE EMS DEPARTMENT