PLEASE BEAR DOWN

RHODE ISLAND PRE-HOSPITAL EXPOSURE FORM

INSTRUCTIONS: Exposed pre-hospital worker completes *Part A* and presents it at hospital emergency department. Hospital ED completes *Part B*, then detaches the carbon copy and presents it to the exposed worker to return to his/her Designated Officer. Appropriate hospital department then completes *Part C* and contacts the exposed worker's Designated Officer (named in *Part A*), regardless of findings.

PART A

Report Date	Time	Incident Date	Time	Receiving Facility for Source Patient

Exposed Worker's Service/Department	EMS Service Incident Number

Exposed Worker Information ***(please print)***

Name _____ **Home Phone** _____ *(optional)*

Designated Officer _____ **Phone** _____

Check boxes which best indicate your exposure. Explain fully in the description space below.

Exposure Route	Bodily fluid splash to
□ Needlestick from used needle □ Injury causing break to skin □ Bite (causing skin break) □ Unprotected mouth-to-mouth CPR □ Other _____ □ Inhalation _____	□ Eye □ Mouth □ Nose □ Non-Intact skin □ Other _____
Exposure Type	**Source Patient**
□ Blood □ Sputum □ Saliva □ Other (*describe*) _____	Name _____ Transp. To _____ D.O.B. _____ Transp. From _____ Location *(when exposure form filed)* _____

Exposed body part(s) ***(be specific)*** _____

_____

Describe the nature of the exposure _____

_____

Have you had Hepatitis B vaccine? □ yes □ no **Hepatitis B antibody status?** □ positive □ negative □ unknown

Protective gear used? □ gown □ mask □ eye shield/goggles □ gloves □ none □ other *(describe)*_____

Did you seek medical attention? □ yes □ no

Where? _____

Signature of Exposed Worker _____

PART B

Exposed worker presented to facility _____ *(name of facility)*

Initial Hospital Disposition (*check all that might apply)*

□ Seen by physician in ED □ Referred to private or contract physician Medical F/U Indicated? □ yes □ no

□ Refused to be seen by ED physician □ Plans to see own physician

Form sent for review to *(check one)* □ Infection Control □ Occupational Health □ Employee Health

□ Other *(specify)* _____

Name of hospital employee receiving form _____ **Date** _____

PART C

FOR HOSPITAL USE ONLY (To be completed by appropriate department)

Source Patient's Name _____ **Source Patient's Hospital Medical Record #** _____

Exposed Worker's Designated Officer *(or name of person contacted)* _____

Date Contacted _____

Exposed worker follow-up indicated? □ yes □ no **Source patient follow-up indicated?** □ yes □ no

Signature _____ **Date** _____