STATE INFECTIOUS DISEASE EXPOSURE REPORT

(To be completed by emergency worker at the time of the exposure)

WARNING: When Filling Out and Submitting This Form Electronically, Be Certain You Are Logged On To YOUR Personal User Account

Incident Number: **Incident Date (mm/dd/yy):** **Time Of Incident (HH:MM):**

First Name: **Last Name:** **MI** **Serial/ID Num:**

Your Home Address:
Street **City** **State** **Zip**

Work Phone(000-000-0000): **Home Phone(000-000-0000):** **Cell Phone(000-000-0000):**

Emergency Worker's/Agency's Physician **Phone:** ☐ Bergan 402-398-6580 ☐ Immanual 402-572-3232

Clinic Name/Address: ☐ AH-Bergan Mercy / 7710 Mercy Rd Ste 124 ☐ AH Immaunal / 6751 N 72nd St Ste 205

Provider Agency: Omaha Fire Department **Phone:** 402-444-3666 Fire

Address: 1516 Jackson St Omaha NE 68102 Fire
Street **City** **State** **Zip**

Exposure Description:

A. Blood or Body Fluids

1. ☐ **Blood or body fluids into natural body openings:** ☐ **Nose** ☐ **Mouth** ☐ **Eyes**
2. ☐ **Blood or body fluids into cuts or wounds less than 24 hours old**
3. ☐ **Blood or body fluids on:** ☐ **Intact Skin** ☐ **Clothing** ☐ **Turn-out Gear** ☐ **PPE**
4. ☐ **Needle stick with contaminated needle**
5. ☐ **Treated or transported known infected patient**
6. ☐ **Other (describe):**

B. Respiratory

1. ☐ **Mouth to mouth resuscitation**
2. ☐ **Resuscitation using airway**
3. ☐ **Coughing of patient with suspected:** ☐ **TB** ☐ **Meningitis** ☐ **Other**

Type Of Fluid To Which You Were Exposed

1. ☐ **Blood** 2. ☐ **Vomit** 3. ☐ **Saliva** 4. ☐ **Feces** 5. ☐ **Urine** 6. ☐ **Airborne**
7. **Other (Describe):**

What You Did To Remove The Contamination From Your Body and Clothing: ☐ **Hand Washing** ☐ **Sanitizer** ☐ **Flush Eyes** ☐ **Remove/Change Clothing** **Other (Provide Details):**

What Protective Dress Were You Wearing At The Time Of Exposure: ☐ **Gloves** ☐ **Gown** ☐ **Goggles** ☐ **N95 Mask** ☐ **Surgical Mask** ☐ **Turnout Gear** **Other(Explain):**

Possible Disease You Were Exposed To:

Any Other Information RELATED To This Incident:

SOURCE OF EXPOSURE:

Patient's Name: **Sex: M** ☐ **F** ☐

Health Care Facility Receiving Patient:

Facility Address:

Patient's Physician:

Type Your Name, ID Number, and Today's Date In The Spaces Provided. Email The Completed Form To The OFD IDCO.
A Copy May Be Printed For Your Records

By Typing Your Name In The Space Provided Below And Sending This Document While Logged On To YOUR Personal Email Account, You Are Stating That The Information You Have Provided In This Document Is True To The Best Of Your Knowledge.

I hereby consent to the release of this information to the source patient's physician and to the health care facility

Name: **Employee ID:** **Date(mm/dd/yy):**

Signature Below Is Required ONLY If Submitting As A Paper Document

Signature

FOR OFFICE USE ONLY Type Exposure: **Exposed To:** **Exposure Route:**
Explain:

Comments: