

Exposure Control

Phone: 888-778-9073 Fax: 877-436-7096

www.tdisdi.com Email: worldhq@tdisdi.com

Original Date: Date Revised:	Original Date:
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All questions contained in this questionnaire are strictly confidential and will become part of your medical record. This is a protected document complying with all applicable Privacy of Information Act standards, HIPAA regulations and OSHA 1910 1030.

This document must be maintained for the life of the employee plus thirty years. Access to this document is strictly prohibited.

Access is only allowed to an authorized department employee and the individual named.

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			INDIVI	DUAL INF	ORM	ATION						
Name: (first, last, mide	dle)						M 🗖 F	DO	В:			
Division: □She	eriff					mergency Mana	ergency Management □EMS □Volunteer					
Date of Exposure: Date						Date of last ph	te of last physical exam:					
				IDENT ST								
How did exposure o			act/Absorption	☐ Inhala	ation	□ Ingestion	Abra	ision	☐ Injectio	on 🗖 Cut		
Immunizations	☐ Tetanus:						☐ Pneumonia:					
and Dates	and Dates Hepatitis:						☐ Chickenpox:					
	☐ Influenza: ☐ MMR(Measles,Mumps,Rube						s,Rubella):					
Describe the incider	nt and	how it occur	red:									
VANIL - 4 '4' 4'	. 4 1			4		. 7						
What mitigation pro		- 1		-	-		<u> </u>					
☐ Semi positive press			☐ Surface supplied air system				☐ Hand washing					
	itive pressure full face mask				· ·	☐ Other ☐ Other						
☐ Divehelmet												
☐ Dry suit w/ hood			☐ Antibacte		own/p	ostdive	 0					
☐ Drygloves			☐ Diver sho					ther				
What mitigation pro	otocols	were used to	o avoid this typ	e of expo	sure?		_					
☐ Semi positive press	sureful	lfacemask	☐ Surface s				☐ Ha	and wa	ashing			
☐ Positive pressure fu	ullface	mask	☐ Positivep	ressureair	deliver	ysystem		ther				
☐ Divehelmet			☐ Freshwat	terwashdo	wn/pc	ost dive		her				
☐ Drysuitw/hood			☐ Antibacte	erial wash d	own/p	ostdive	-	her				
□ Drygloves			☐ Diver sho	ower			 • •	her				
Have you ever had a	blood	l transfusion	?						☐ Ye	s 🗖 No		

DuringDive	☐ Immediately After Dive ☐ Within 24 hours after dive ☐ 24 – 72 hours after dive ☐ How did the effects present itself? (Che ☐ Itch ☐ Rash ☐ Lesion ☐ Burn ☐ Blister
□ Within 24 hours after dive □ 14 - 30 days after dive □ 1 - 3 years after dive □ 24 - 72 hours after dive □ 1 - 3 months after dive □ 3 - 5 years after dive How did the effects present itself? (Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain □ Itch □ Drastic changes in weight: □ Rash □ Tingling in the extremities □ Vision Problems □ Lesion □ Muscle Aches/Pain □ Headaches □ Burn □ Tremors/Body Shakes/Seizures □ MemoryLoss/Mood Changes □ Blister □ GID/Diarrhea/Vomiting □ Other: □ Discolored SkinTissue □ Paralysis □ Other: FYOU WERE SEEN BY A PHYSICIAN Drs. Name: (first, last, middle) Date of exam: Address:	 □ Within 24 hours after dive □ 24 – 72 hours after dive How did the effects present itself? (Checological Properties of the properties
□ 24 − 72 hours after dive □ 1 − 3 months after dive □ 3 − 5 years after dive How did the effects present itself? (Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain □ Itch □ Acne/PUS □ Drastic changes in weight: □ Rash □ Tingling in the extremities □ Vision Problems □ Lesion □ Muscle Aches/Pain □ Headaches □ Burn □ Tremors/Body Shakes/Seizures □ MemoryLoss/MoodChanges □ Blister □ GID/Diarrhea/Vomiting □ Other: □ Discolored Skin Tissue □ Paralysis □ Other: □ Other: □ Drs. Name: (first, last, middle) Contact #: Date of exam: Address:	□ 24 – 72 hours after dive How did the effects present itself? (Che □ Itch □ Rash □ Lesion □ Burn □ Blister
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□ Itch □ Acne/PUS □ Drasticchangesin weight: □ Rash □ Tingling in the extremities □ Vision Problems □ Lesion □ Muscle Aches/Pain □ Headaches □ Burn □ Tremors/Body Shakes/Seizures □ MemoryLoss/MoodChanges □ Blister □ GID/Diarrhea/Vomiting □ Other: □ Discolored Skin Tissue □ Paralysis □ Other: IF YOU WERE SEEN BY A PHYSICIAN Drs. Name: (first, last, middle) Contact #: Address: Date of exam:	□ Itch □ Rash □ Lesion □ Burn □ Blister
□ Rash □ Tingling in the extremities □ Vision Problems □ Lesion □ Muscle Aches/Pain □ Headaches □ Burn □ Tremors/Body Shakes/Seizures □ Memory Loss/Mood Changes □ Blister □ GID/Diarrhea/Vomiting □ Other: □ Discolored Skin Tissue □ Paralysis □ Other: IF YOU WERE SEEN BY A PHYSICIAN Drs. Name: (first, last, middle) Address: Date of exam:	□ Rash □ Lesion □ Burn □ Blister
□ Lesion □ Muscle Aches/Pain □ Headaches □ Burn □ Tremors/Body Shakes/Seizures □ MemoryLoss/MoodChanges □ Blister □ GID/Diarrhea/Vomiting □ Other: □ Discolored Skin Tissue □ Paralysis □ Other: IF YOU WERE SEEN BY A PHYSICIAN Drs. Name: (first, last, middle) Contact #: Date of exam: Address:	☐ Lesion ☐ Burn ☐ Blister
□ Burn □ Tremors/Body Shakes/Seizures □ MemoryLoss/MoodChanges □ Blister □ GID/Diarrhea/Vomiting □ Other: □ Discolored SkinTissue □ Paralysis □ Other: IF YOU WERE SEEN BY A PHYSICIAN Drs. Name: (first, last, middle) Contact #: Date of exam: Address:	☐ Burn ☐ Blister
□ Blister □ GID/Diarrhea/Vomiting □ Other: □ Discolored SkinTissue □ Paralysis □ Other: IF YOU WERE SEEN BY A PHYSICIAN Drs. Name: (first, last, middle) Contact #: Date of exam: Address:	☐ Blister
□ Discolored Skin Tissue □ Paralysis □ Other: IF YOU WERE SEEN BY A PHYSICIAN Drs. Name: (first, last, middle) Contact #: Date of exam: Address:	
IF YOU WERE SEEN BY A PHYSICIAN Drs. Name: (first, last, middle) Address: Date of exam:	
Drs. Name: (first, last, middle) Address: Contact #: Date of exam:	■ Discolored SkinTissue
Drs. Name: (first, last, middle) Address: Contact #: Date of exam:	
Address:	
	Drs. Name: (first, last, middle)
Was prescription issued: Yes No Was a diagnosis determined: Yes No	Address:
	Was prescription issued: ☐ Yes ☐ No
Individual's Name: (Last, First, M.I.): Date: Recorder Name: (Last, First, M.I.): Date:	Individual's Name: (Last, First, M.I.):
Signature: Signature:	Cianatura
	Signature: