



Please Note: This report is intended to be used by Emergency Service Organizations for internal use only. It is not an acceptable VFIS Claims form and therefore should not be submitted to VFIS.

# Infectious Exposure Form

Exposed Member's Name: \_\_\_\_\_ Position: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Field Inc. #: \_\_\_\_\_ Shift: \_\_\_\_\_ Company: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Sex: \_\_\_\_\_

Age: \_\_\_\_\_ Address: \_\_\_\_\_

Suspected or Confirmed Disease: \_\_\_\_\_

Transported to: \_\_\_\_\_

Transported by: \_\_\_\_\_

Date of Exposure: \_\_\_\_\_ Time of Exposure: \_\_\_\_\_

Type of Incident (auto accident, trauma): \_\_\_\_\_

Type of protective equipment utilized: \_\_\_\_\_

What where you exposed to:

Blood \_\_\_\_\_ Tears \_\_\_\_\_ Feces \_\_\_\_\_ Urine \_\_\_\_\_ Saliva \_\_\_\_\_

Vomit \_\_\_\_\_ Sputum \_\_\_\_\_ Sweat \_\_\_\_\_ Other \_\_\_\_\_

What part(s) of your body became exposed? Be specific: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you have any open cuts, sores, or rashes that became exposed? Be specific: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did exposure occur? Be specific: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you seek medical attention? \_\_\_\_\_Yes \_\_\_\_\_No

Where? \_\_\_\_\_ Date: \_\_\_\_\_

Contact Infection Control Supervisor: Date \_\_\_\_\_ Time: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Infection Control Supervisor's Report

Medical facility notified? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes:

Name of Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Name of Facility Contact: \_\_\_\_\_

Confirmed Exposure: \_\_\_\_\_

Member notified? Yes \_\_\_\_\_ No \_\_\_\_\_

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Follow-Up Action:

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Remarks:

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Infection Control Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_