Appendix 3
REPORT OF POSSIBLE EXPOSURE TO TRANSPORTER

Any transporter who has one of the exposures listed in #2 below must complete this form immediately. The completed form should be placed in the designated receptacle provided by the hospital where the patient is delivered. Items 1-5 are to be completed by the transporter. Questions in the box are to be completed by the hospital.

Please Print Legibly

Items 1-5 to be completed by the Transporter.

1. The exposure described in #2 below occurred in the care of the following patient/person:
____ on ____/____/____ at
(Patients Name)
________am/pm taken to: ____
(Facility)

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Hospitals: Cut on dotted line and send this lower portion only to the health authority.
You may wish to keep a copy for your records.

2. Describe the details of contact with blood or body fluids.

TYPE OF EXPOSURE (Check those that apply)	ADDITIONAL DESCRIPTION
____ Mouth to mouth resuscitation	___________________________
____ Intubation	___________________________
____ Throat Exam	___________________________
____ Suctioning	___________________________
____ Blood and/or	
____ body fluid contact with:	
____ Eyes	____________________________
____ Nose	____________________________
____ Mouth	____________________________
____ Puncture/cut w/needle or sharp object	____________________________
____ Open wound lesion	____________________________
____ Non-intact skin	____________________________

Self-first aid must be done as soon as possible following one of the above exposures. Rinse/Flush thoroughly the body part exposed to blood or body fluids.
Follow with anti-microbial scrubbing of the exposed area, if not contraindicated, (i.e. eyes, etc.)

3. Transporter Name: ____
   Telephone: (home)____________________________(work)___________________________
4. Name of Employer/Agency (EMS/Fire/Police): ____________________________________
   Address: _______________________ City: ___________________Phone: _______________

5. Transporter Signature: __________________________Date form completed: ___________
Transporter; Now place form in designated receptacle

TO BE COMPLETED BY THE HOSPITAL:

____ DISEASE IDENTIFIED ______________________________ ____/____/_____
(Name of disease) (Date specimen collected)
____ NO DISEASE IDENTIFIED DURING THIS HOSPITALIZATION

REPORTED TO HEALTH AUTHORITY BY TELEPHONE (for true exposures only)
Name of Agency __________________________Person Contacted ____________________
Date Contacted ____/____/____ By: ____________________________
Name/Title of Person completing this Section: __________________________________
Signature: ____ Date ____/____/____