COUNTY OF RIVERSIDE DEPARTMENT OF PUBLIC HEALTH 4065 COUNTY CIRCLE DRIVE, RIVERSIDE, CA 92503

PHONE: (951) 358-5107 FAX: (951) 358-5102

COMMUNICABLE DISEASE EXPOSURE REQUEST FORM

| 2 | EMPLOYER | | | | |
|---|---|--|--|----------------------|--|
| EMPLOYEE INFORMATION | EMPLOYEE NAME | | | | |
| | SOCIAL SECURITY NUMBER | | | | |
| PL(RM | DATE OF EXPOSURETIME | | | | |
| EM FO | DATE REPORTED TIME | | | | |
| Z | REPORTED TO | | | | |
| | EMPLOYEE'S SUPERVISOR (if different than above) | | | | |
| | ROUTE OF ENTRY ☐ NEEDLE STICK ☐ MOUTH ☐ SKIN | ☐ RESPIRATORY ☐ | EYES | | |
| | OTHER (specify) | | | | |
| | TYPE OF SECRETION BLOOD SALIVA URINE D | MUCOUS VOMITUS | ☐ FECES ☐ TEARS ☐ S | SWEAT | |
| ы N | OTHER (specify) CLEAR. CONCISE DESCRIPTION OF EXPOSURE (Include proximity to | notiont\ | | | |
| R Ľ | CLEAR, CONCISE DESCRIPTION OF EXPOSORE (INClude proximity to | patient) | | | |
| OS | | | | | |
| EXPOSURE DESCRIPTION | | | | | |
| 9 B | | | SEE ATTACHED PAG | FOR MORE INFORMATION | |
| | PERSONAL PROTECTIVE EQUIPMENT UTILIZED | | | | |
| | ☐ GLOVE ☐ GOWN ☐ EYE PROTECTION (specify type) | | | | |
| | RESPIRATORY PROTECTION (specify type) | | | | |
| Ä | INITIAL EXPLANATION AND/OR EXPOSURE CARE RENDERED TO EM | PLOYEE? YES | NO | | |
| | Where? | Physician _ | | | |
| CAF | Copy of form forwarded to employee's supervisor? |] NO | | | |
| FIRST CARE | Original form forwarded to designated officer? |] NO | | | |
| IRS | | | | | |
| ш | SIGNATURE OF PERSON COMPLETING FORM | TITLE | | DATE | |
| _ | (Forward to Department Designated Officer) | | | | |
| NO | PATIENT NAME | | | | |
| SCE INT ATI | ADDRESSPATIENT DESTINATION | | | | |
| SOURCE PATIENT INFORMATION | | | BOOKING# | | |
| | SUSPECTED COMMUNICABLE DISEASE | | | | |
| _ ≥ | PATIENT HX | | | | |
| | POSSIBLE EXPOSURE? | YES NO | | | |
| | | | | | |
| | - | YES NO DATE | | | |
| Z | SOURCE PATIENT'S HOSPITAL CONTACTED? | | | | |
| _ | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? | | | | |
| _ | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? | YES NO DATE | | | |
| _ | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUEST | YES NO DATE | | | |
| SOURCE PATIENT FORMATIO | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? | YES NO DATE | | | |
| 0 | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUES Hospital Contact's Name and Position | YES □ NO DATE YES □ NO T FORM DATE | | DATE | |
| SOURCE PATIENT FORMATIO | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUEST | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI | ER | DATE | |
| SOURCE PATIENT INFORMATIO REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUES Hospital Contact's Name and Position SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER (Forward photocopies to hospital, return original copy to Designated O | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho | ER spital) | DATE | |
| SOURCE PATIENT INFORMATIO REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUES Hospital Contact's Name and Position SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER (Forward photocopies to hospital, return original copy to Designated OFFICER EXPOSURE CONFIRMED? | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho | ER | DATE | |
| SOURCE PATIENT INFORMATIO REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUEST Hospital Contact's Name and Position SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER (Forward photocopies to hospital, return original copy to Designated OFFICER EXPOSURE CONFIRMED? NO REPORTABLE CD IDENTIFIED WITHIN 48 HOURS | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho | ER spital) | DATE | |
| SOURCE PATIENT INFORMATIO REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUES Hospital Contact's Name and Position SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER (Forward photocopies to hospital, return original copy to Designated OFFICER EXPOSURE CONFIRMED? NO REPORTABLE CD IDENTIFIED WITHIN 48 HOURS REPORTABLE CD DIAGNOSED (specify) | YES NO DATE YES NO DATE TELEPHONE NUMBI fficer after completion by ho YES NO DATE | ER spital) | | |
| SOURCE PATIENT INFORMATIO REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUES Hospital Contact's Name and Position SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER (Forward photocopies to hospital, return original copy to Designated OFFICER EXPOSURE CONFIRMED? NO REPORTABLE CD IDENTIFIED WITHIN 48 HOURS REPORTABLE CD DIAGNOSED (specify) | YES NO DATE YES NO DATE TELEPHONE NUMBI fficer after completion by ho YES NO DATE | ER spital) | DATE | |
| SOURCE PATIENT INFORMATIO REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho /ES NO DATE | ER spital) :CONTACT NAME | | |
| HOSPITAL SOURCE DETERMINATION PATIENT (Hospital Health INFORMATIO Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUES Hospital Contact's Name and Position SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER (Forward photocopies to hospital, return original copy to Designated OFFICER EXPOSURE CONFIRMED? NO REPORTABLE CD IDENTIFIED WITHIN 48 HOURS REPORTABLE CD DIAGNOSED (specify) | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho /ES NO DATE | ER spital) :CONTACT NAME | | |
| HOSPITAL SOURCE DETERMINATION PATIENT (Hospital Health INFORMATIO Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUES Hospital Contact's Name and Position SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER (Forward photocopies to hospital, return original copy to Designated OFFICER NO REPORTABLE CD IDENTIFIED WITHIN 48 HOURS REPORTABLE CD DIAGNOSED (specify) PUBLIC HEALTH NOTIFIED? YES NO DATE SIGNATURE OF HOSPITAL HEALTH CARE PROFESSIONAL TIT | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho /ES NO DATE | ER spital) : CONTACT NAME TELEPHONE NU | | |
| HOSPITAL SOURCE DETERMINATION PATIENT (Hospital Health INFORMATIO Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES VERBALLY COPY OF REQUES Hospital Contact's Name and Position SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER (Forward photocopies to hospital, return original copy to Designated OFFICER NO REPORTABLE CD IDENTIFIED WITHIN 48 HOURS REPORTABLE CD DIAGNOSED (specify) PUBLIC HEALTH NOTIFIED? YES NO DATE SIGNATURE OF HOSPITAL HEALTH CARE PROFESSIONAL TIT | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho YES NO DATE | ER spital) : CONTACT NAME TELEPHONE NU | | |
| HOSPITAL SOURCE DETERMINATION PATIENT (Hospital Health INFORMATIO Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho YES NO DATE | ER spital) : CONTACT NAME TELEPHONE NU | | |
| HOSPITAL SOURCE DETERMINATION PATIENT (Hospital Health INFORMATIO Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho YES NO DATE | ER spital) : CONTACT NAME TELEPHONE NU | | |
| IE HOSPITAL SOURCE ION DETERMINATION PATIENT Ed (Hospital Health INFORMATIO Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES | YES NO DATE YES NO T FORM DATE TELEPHONE NUMBI fficer after completion by ho YES NO DATE | ER spital) : CONTACT NAME TELEPHONE NU | | |
| HOSPITAL SOURCE DETERMINATION PATIENT (Hospital Health INFORMATIO Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES | YES NO DATE YES NO DATE TELEPHONE NUMBI fficer after completion by ho ZES NO DATE TITLE | ER spital) : CONTACT NAME TELEPHONE NU | MBER DATE | |
| EMPLOYEE HOSPITAL SOURCE NOTIFICATION DETERMINATION PATIENT (Designated (Hospital Health INFORMATIO Officer) Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES | YES NO DATE YES NO DATE TELEPHONE NUMBI fficer after completion by ho YES NO DATE | ER spital) : CONTACT NAME TELEPHONE NU | MBER DATE | |
| EMPLOYEE HOSPITAL SOURCE NOTIFICATION DETERMINATION PATIENT (Designated (Hospital Health INFORMATIO Officer) Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES | YES NO DATE YES NO DATE TELEPHONE NUMBI fficer after completion by ho ZES NO DATE TITLE | ER spital) : CONTACT NAME TELEPHONE NU | MBER DATE | |
| HOSPITAL SOURCE DETERMINATION PATIENT (Hospital Health INFORMATIO Care Provider) REQUEST | SOURCE PATIENT'S HOSPITAL CONTACTED? EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? EMPLOYEE NOTIFIED OF REQUEST? IF YES | YES NO DATE YES NO DATE TELEPHONE NUMBI fficer after completion by ho ZES NO DATE TITLE | ER spital) : CONTACT NAME TELEPHONE NU | MBER DATE | |

| | FOI | R DISEASE CONTROL | USE ONLY | |
|--------|--|-------------------|--------------------------|------|
| OSITIO | FOLLOW-UP RECOMMENDATIONS PROVIDED? ERE DIAGNOSED WITH COMMUNICA COMMENTS SIGNATURE | | TO □ NO DATE CASE CLOSED | DATE |