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

EMPLOYEE INFORMATION

EMPLOYER _____

EMPLOYEE NAME _____ TODAY'S DATE _____ INCIDENT # _____

SOCIAL SECURITY NUMBER _____ ASSIGNMENT _____

DATE OF EXPOSURE _____ TIME _____ LOCATION _____

DATE REPORTED _____ TIME _____

REPORTED TO _____ TITLE _____

EMPLOYEE'S SUPERVISOR (if different than above) _____

EXPOSURE DESCRIPTION

ROUTE OF ENTRY ☐ NEEDLE STICK ☐ MOUTH ☐ SKIN ☐ RESPIRATORY ☐ EYES

☐ OTHER (specify) _____

TYPE OF SECRETION ☐ BLOOD ☐ SALIVA ☐ URINE ☐ MUCOUS ☐ VOMITUS ☐ FECES ☐ TEARS ☐ SWEAT

☐ OTHER (specify) _____

CLEAR, CONCISE DESCRIPTION OF EXPOSURE (Include proximity to patient)

_____

_____

_____

☐ SEE ATTACHED PAGE FOR MORE INFORMATION

PERSONAL PROTECTIVE EQUIPMENT UTILIZED

☐ GLOVE ☐ GOWN ☐ EYE PROTECTION (specify type) _____

RESPIRATORY PROTECTION (specify type) _____

FIRST CARE

INITIAL EXPLANATION AND/OR EXPOSURE CARE RENDERED TO EMPLOYEE? ☐ YES ☐ NO

Where? _____ Physician _____

Copy of form forwarded to employee's supervisor? ☐ YES ☐ NO

Original form forwarded to designated officer? ☐ YES ☐ NO

_____ _____ _____

SIGNATURE OF PERSON COMPLETING FORM (Forward to Department Designated Officer) | TITLE | DATE

SOURCE PATIENT INFORMATION

PATIENT NAME _____ DOB _____ PHONE # _____

ADDRESS _____ MEDICAL RECORD # _____

PATIENT DESTINATION _____ IN CUSTODY ☐ YES ☐ NO

TRANSPORTED BY _____ BOOKING # _____

SUSPECTED COMMUNICABLE DISEASE _____

PATIENT HX _____

SOURCE PATIENT INFORMATION REQUEST

POSSIBLE EXPOSURE? ☐ YES ☐ NO

SOURCE PATIENT'S HOSPITAL CONTACTED? ☐ YES ☐ NO DATE _____

EXPOSURE DETERMINATION BY HOSPITAL REQUESTED? ☐ YES ☐ NO DATE _____

EMPLOYEE NOTIFIED OF REQUEST? ☐ YES ☐ NO

IF YES ☐ VERBALLY ☐ COPY OF REQUEST FORM DATE _____

Hospital Contact's Name and Position _____

_____ _____ _____

SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER | TELEPHONE NUMBER | DATE

(Forward photocopies to hospital, return original copy to Designated Officer after completion by hospital)

HOSPITAL DETERMINATION (Hospital Health Care Provider)

EXPOSURE CONFIRMED? ☐ YES ☐ NO DATE: _____

☐ NO REPORTABLE CD IDENTIFIED WITHIN 48 HOURS

☐ REPORTABLE CD DIAGNOSED (specify) _____

PUBLIC HEALTH NOTIFIED? ☐ YES ☐ NO DATE _____ CONTACT NAME _____

_____ _____ _____ _____

SIGNATURE OF HOSPITAL HEALTH CARE PROFESSIONAL | TITLE | TELEPHONE NUMBER | DATE

EMPLOYEE NOTIFICATION (Designated Officer)

EMPLOYEE NOTIFIED? ☐ YES ☐ NO DATE: _____

EXPLANATION: _____

_____

_____ _____ _____

SIGNATURE OF EMPLOYEE'S DESIGNATED OFFICER | TITLE | DATE

OTHER AGENCIES INVOLVED

AGENCY NAME	CONTACT PERSON	TELEPHONE #

Distribution: WHITE—DESIGNATED OFFICER; COPY TO: HOSPITAL, EMPLOYEE AND DOPH.

FOR DISEASE CONTROL USE ONLY	
FINAL DISPOSITION FOR ERE	FOLLOW-UP RECOMMENDATIONS PROVIDED? ☐ YES ☐ NO DATE _____ TO ☐ ERE ☐ DO ERE DIAGNOSED WITH COMMUNICABLE DISEASE ☐ YES ☐ NO DATE CASE CLOSED _____ COMMENTS _____ _____ _____ _____ SIGNATURE TITLE DATE