



CENTRAL DUPAGE HOSPITAL EMERGENCY MEDICAL SERVICES SYSTEM

25 NORTH WINFIELD ROAD
WINFIELD, IL 60190

PHONE: 630.933.6910
WEBSITE: WWW.CDHEMS.COM

SIGNIFICANT EXPOSURE REPORTING FORM FOR PRE-HOSPITAL PROVIDERS

REFERENCE: SYSTEM POLICY #O-22 PRECAUTIONS FOR INFECTIOUS DISEASE AND DISINFECTION PROCEDURE

THE FOLLOWING FORM WILL BE UTILIZED WHEN PRE-HOSPITAL PROVIDERS HAVE RECEIVED SIGNIFICANT EXPOSURE TO BLOOD OR BODY FLUIDS.

FOR THE PURPOSE OF THIS FORM, 'SIGNIFICANT EXPOSURE' SHALL INCLUDE:

- A. PARENTERAL EXPOSURE TO BLOOD OR BODY FLUIDS THROUGH LACERATIONS, NEEDLE STICKS, ABRASIONS, AND OTHER BREAKS IN SKIN INTEGRITY
- B. MUCOUS MEMBRANE EXPOSURE TO BLOOD OR BODY FLUIDS OF A PATIENT VIA SPLASH OF THE EYES, NOSE, OR MOUTH.

INSTRUCTIONS:

- 1. NOTIFY THE EMERGENCY DEPARTMENT CHARGE NURSE AT CENTRAL DUPAGE HOSPITAL OF THE SIGNIFICANT EXPOSURE. THIS MAY BE DONE IN PERSON OR VIA PHONE AT 630.933.1408
- 2. THE E.D. CHARGE NURSE WILL NOTIFY E.D. PHYSICIAN OF THE EXPOSURE
- 3. COMPLETE THIS FORM AND GIVE TO E.D. CHARGE NURSE
- 4. IF NEEDED, MEDICAL EVALUATION AND TREATMENT MAY BE PROVIDED.
- 5. THE EMPLOYEE HEALTH NURSE MAY BE NOTIFIED AT THE TIME OF EXPOSURE FOR FURTHER FOLLOW-UP.

NAME OF EMS PROVIDER WITH SIGNIFICANT EXPOSURE:	_____	EMS PROVIDER AGENCY:	_____
DATE OF EXPOSURE:	___/___/___	TIME OF EXPOSURE:	_____ HRS
NAME OF PATIENT:	_____	MEDICAL RECORD NUMBER (IF KNOWN):	_____
NATURE OF EXPOSURE (CIRCLE):	BLOOD SALIVA	OTHER:	_____
EXPOSURE TYPE (CIRCLE):	PARENTERAL MUCOUS MEMBRANE	SPLASH / CONTACT	

SYNOPSIS OF EXPOSURE EVENT:

NAME OF CHARGE NURSE:	_____	SIGNATURE:	_____
NAME OF E.D. PHYSICIAN:	_____	SIGNATURE:	_____
NAME OF EMS PROVIDER:	_____	SIGNATURE:	_____

DATE RECEIVED BY EMPLOYEE HEALTH RN: ___/___/___

SIGNIFICANT EXPOSURE REPORTING FORM