Mary Washington Healthcare

Memorandum

To: EMS Agencies

From: Tina Skinner, EMS Coordinator

Date: February 25, 2013

Subject: EMS Exposure Forms

The following packet contains updated regional and hospital based forms made available should EMS personnel need to report an occupational exposure or request source patient testing.

If you have an exposure, immediately contact your Agency Infection Control Officer and complete the following forms:

Regional Occupational Exposure / Source Testing Report

- After delivery of a possible source patient to the Emergency Department, complete this form and submit to the Patient Care Manager or Charge Nurse. The form should then be faxed to Tami Jeffries, Health & Wellness Department.
- Failure to provide completed documents at the time of patient delivery to the Emergency Department can result in the lost opportunity of obtaining the appropriate lab screenings on a possible source patient.
- Maintain a copy of the regional exposure form for your EMS Agency Infection Control Officer and records.

Mary Washington Healthcare Emergency Medical Services Exposure Report

- This form should accompany the completed REMS Occupational Exposure / Source Testing Report.
- Complete top section of MWHC form and submit to the Emergency Department Patient Care Manager or Charge Nurse.
- An Emergency Department Physician or Nurse will evaluate the exposure as requested and complete additional information on both forms as indicated.
- Maintain a copy of the completed form for your own record.
- Fax both forms to MWHC Associate Wellness, who will follow up with Infection Control Officer as needed.

Upon completion of these forms, be sure they are faxed by the ED Patient Care Manager / Charge Nurse as soon as possible to Tami Jeffries of MWHC Health &Wellness at 540-741-3614

Rappahannock Emergency Medical Services, Inc.

Occupational Exposure / Source Testing Report

Agency:	Date:

Part I: Patient Information

Name (Last, First, MI):

Sex:	Age:	DOB:	Social Security#:

Part II: Exposure Information

A. Exposed to: Blood ☐ Saliva ☐ Tears ☐ Emesis ☐ Feces ☐ Sputum ☐ Urine ☐ Other(specify) ☐

B. Route of exposure: Percutaneous ☐ Mucous Membranes ☐ Open Skin(cut, etc.) ☐ Dermatitis ☐ Other(specify) ☐

C. Area exposed: Hand/Finger ☐ Nose/Mouth ☐ Face ☐ Eye ☐ Arm ☐ Leg ☐ Torso ☐ Other(specify) ☐

D. Visible blood on device or in fluid? Yes ☐ No ☐

E. Amount of blood/body fluid exposed to: Minor ☐ Moderate ☐ Major ☐

F. How deep was the injury? Superficial(scratch) ☐ 0.25cm ☐ 0.5cm ☐ Deep ☐

G. Type of device: IV /Hollow-bore needle ☐ Butterfly ☐ Scalpel ☐ Lancet ☐ Knife blade ☐ Other(specify) ☐ N/A ☐

H. Was the needle in an artery or vein? Yes ☐ No ☐ N/A ☐

I. PPE used: Uniform ☐ Gown ☐ Eye Protection ☐ Firefighting protective equipment ☐ Patient Care Gloves ☐ Mask ☐ Leather/Extrication Gloves ☐ Other(specify) ☐

J. Procedure being performed: Hemorrhage Control ☐ IV/Medication Administration ☐ Sharps Disposal ☐ Finger Stick Airway Management ☐ Decontamination ☐ Passing Instrument ☐ Other(specify) ☐

Part III: Employee Information

Name (Last, First, MI):	Contact #:
Exposure date:	Exposure time:
Receiving facility of patient:	Patient's receiving facility room #:
Receiving nurse/physician:	Nurse/physician's contact #:

Part IV: Infection Control Officer Requesting Source Testing

Inf. control officer (PRINT):	Inf. control officer contact #::
Date notified of exposure:	Time notified of exposure:
Date request was faxed to facility:	Time request was faxed to facility:

Part V: Facility Receiving Request (TO BE COMPLETED BY CHARGE NURSE/PHYSICIAN)

Name Of Facility:		Contact #:	Fax #:
File #:	Patient history #:	Unit/Room # patient admitted to:	

Date/Time request was received:	Date/Time request was completed:

Charge Nurse/Physician who received and completed request (PRINT):

Charge Nurse/Physician who received and completed request (SIGNATURE):

REMINDER TO INFECTION CONTROL OFFICER:

Fax or deliver a copy of this form to the appropriate hospital where the patient was transported:

- **CULPEPER REGIONAL HOSPITAL** - Betsy Holzworth – Infection Control, **Phone**: 540-829-4385; **Fax**: 540-829-8804
- **FAUQUIER HOSPITAL** – Mary Spurrell - Infection Control Practioner, **Phone**: 540-316-4735; Fax: 540-316-4731
- **MARY WASHINGTON HOSPITAL** – Tami Jeffries – Health & Wellness, **Phone**: 540-741-3621; **Fax**: 540-741-3614; Located in the Medical Arts Bldg..
- **SPOTSYLVANIA REGIONAL MEDICAL CENTER** –Susanna Sullard - Infection Preventionist, **Phone**: 540-498-4488; **Fax**: 540-498-4925

Special Notes:

- Please retain a copy of this forms for your records
- Completion of this form does not release you from any agency reporting obligation

Mary Washington Healthcare

EMS Blood/Body Fluid Exposure Info Sheet

Date: ________________

Time: ________________

EMS PROVIDER

Name of EMS provider: ____

EMS Department: ______________________________ Contact #: __________

Infection control officer: ____________________________ Contact #: __________

Source patient's name: __________________________ MRN: ________________

Type of exposure: Blood ____ Body fluid (specify) ______________

Brief description of how exposure happened: ________________________________

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Hepatitis B vaccine: Yes ___ No ___ Unknown ___

Hepatitis B status (Have you had blood drawn to determine immunity?) Immune / Non-immune

NURSE

Order the EMPL needlestick protocol on source patient, should include a rapid HIV.

Employee needlestick protocol ordered at ____________ by ______________________
Time

Infection Control Officer called with Rapid HIV result at _________ by ________________
Time Nurse

Charge Nurse: ______________________________ Contact #: _______________

Please fax this form to 741-3614 with the REMS (EMS) exposure report. Thank you.