

**AEROSOL TRANSMISSIBLE DISEASE
EXPOSURE ANALYSIS**

 See GENERAL INSTRUCTIONS on Last Page

EXPOSURE LOG NO.: _____

FORM TO BE COMPLETED BY INFECTION CONTROL AND PREVENTION STAFF

TODAY'S DATE:		NAME OF PERSON REPORTING POSSIBLE EXPOSURE:		CONTACT PHONE NO.:	
DATE OF EXPOSURE:		TIME OF EXPOSURE: <input type="checkbox"/> AM / <input type="checkbox"/> PM		LOCATION OF EXPOSURE (Building Location, Work Area/Unit, Room No.):	
EXPOSURE: <input type="checkbox"/> Avian Influenza <input type="checkbox"/> Mumps <input type="checkbox"/> SARS <input type="checkbox"/> Hemorrhagic Fevers <input type="checkbox"/> Novel Influenza <input type="checkbox"/> Smallpox <input type="checkbox"/> Influenza A H1N1 <input type="checkbox"/> Pertussis <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Meningitis <input type="checkbox"/> Rubella (German measles) <input type="checkbox"/> Varicella (Chicken Pox) <input type="checkbox"/> Monkeypox <input type="checkbox"/> Rubeola (Measles) <input type="checkbox"/> Other: _____					
SOURCE INFORMATION					
PATIENT LAST NAME:		FIRST, MIDDLE NAME:		DATE OF BIRTH:	MEDICAL RECORD #:
PHYSICIAN/SERVICE:			DIAGNOSIS/REASON FOR ADMISSION, <i>if applicable</i> :		
DESCRIPTION OF THE EXPOSURE INCIDENT: _____ _____ _____ _____					
OTHER SIGNIFICANT INFORMATION (COUGHING, MDR-Tb, HIV, etc.):					
DEPARTMENT/SERVICES SOURCE PATIENT HAD UNPROTECTED CONTACT WITH (NOT ON APPROPRIATE ISOLATION):					
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Pediatric Emergency	<input type="checkbox"/> Psych Emergency	<input type="checkbox"/> PACU		
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Radiology	<input type="checkbox"/> OR/Surgery	<input type="checkbox"/> Social Services		
<input type="checkbox"/> Nutrition/Dietary	<input type="checkbox"/> Environmental Services	<input type="checkbox"/> Safety Police	<input type="checkbox"/> Bronch		
<input type="checkbox"/> OT/PT/SP	<input type="checkbox"/> Laboratory	<input type="checkbox"/> GI Lab	<input type="checkbox"/> Floor: _____		
<input type="checkbox"/> Volunteer Office	<input type="checkbox"/> Outpatient Clinic: _____	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Other: _____		
COMMENTS: _____ _____ _____ _____					

Send this completed form to Employee Health Services (EHS)-by e-mail or fax. Each Service Director or designee must review their patient assignments and instruct exposed Workforce Members (WFMs) to report to EHS. Send the list of exposed WFMs (ATTACHMENT G) to EHS.

 **GENERAL INSTRUCTIONS**

Infection Control is to send this form to EHS. Each Service Director or designee must review their patient assignments and instruct exposed WFMs to report to EHS. Send the list of exposed WFMs to EHS.

**A COPY OF THE AEROSOL TRANSMISSIBLE DISEASE STANDARD CAN BE OBTAINED AT
<http://www.dir.ca.gov/title8/5199.html>**