Health Services
LOS ANGELES COUNTY

WORKFORCE MEMBER
NOVEL CORONAVIRUS (COVID-19)
EXPOSURE EVALUATION

EXPOSURE LOG NO.:

Last Name:	**First Name:**	**Birthdate:**		**Employee#/C#:**
Job Classification:	**Item:**	**Work Facility:**	**Dept#/PL:**	**Dept/Division:**
Email Address:	**Contact Phone:**	**Supervisor's Name:**		

EXPOSURE/CONTACT INFORMATION - Source known positive for COVID-19		
Date/Dates of Exposure:		
When caring for the patient were you wearing a surgical mask?	□ Yes	□ No
When caring for the patient were you wearing a N95 respirator?	□ Yes	□ No
When caring for the patient were you wearing either a PAPR/CAPR respirator?	□ Yes	□ No
When caring for the patient were you wearing eye protection?	□ Yes	□ No
Were you performing or in close proximity for procedures that generated aerosols AGP?		
Intubation procedures	□ Yes	□ No
Bronchoscopy	□ Yes	□ No
High-flow oxygen nasal canula (airflow delivered at 40-60 LPM)	□ Yes	□ No
BiPAP/CPAP	□ Yes	□ No
Sputum induction	□ Yes	□ No
Nebulized treatment	□ Yes	□ No
CPR	□ Yes	□ No
Other_____	□ Yes	□ No
Did you have direct exposure to droplets from respiratory sections (cough/sneeze) to your mucus membranes?	□ Yes	□ No

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS SINCE YOUR EXPOSURE?				
Symptom	Yes	No	Onset Date/Time	Duration of Symptoms
Fever				
Cough				
Sore Throat				
Shortness of Breath or Difficulty Breathing				
Chills or repeated shaking with chills				
Muscle pain				
Headache				
New loss of taste or smell				

EMPLOYEE SIGNATURE:	
Signature:	Date/Time:

EMPLOYEE HEALTH SERVICES INITIAL VISIT	
Initial Evaluation Date:	Temperature:
□ Symptomatic WFM, place mask on WFM, consult with EHS provider. Referred to Primary Care Provider/IA Provider. Remove from work. Testing options include: EHS, personal healthcare provider or community testing	
OR	
□ Asymptomatic WFM, identify risk group below:	
□ **High Risk:** exclude from work for 14 days after last exposure, self-monitoring	
□ Performed or in close proximity during procedures that generated aerosols, with unprotected eyes	
□ Performed or in close proximity during procedures that generated aerosols, with unprotected nose	
□ Performed or in close proximity during procedures that generated aerosols, with unprotected mouth	
□ Direct exposure to droplets from respiratory sections (cough/sneeze/kissing) to mucus membranes	
□ Sharing unwashed utensils/drinking glasses, toothbrushes, etc.	

Health Services
LOS ANGELES COUNTY

□ Co-habituating in same bed
□ Instructed to return self-monitoring log to EHS once complete and prior to retuning to work
□ **Non-High Risk:** No work restrictions
□ WFM used all appropriate PPE with all encounters with source patient
□ Wore eye, nose and mouth protection when performed or in close proximity during an AGP
□ No direct contact with positive case
□ WFM who walked by a patient or who had no direct contact to source secretions/excretions
COMMENTS
EHS SIGNATURE INITIAL VISIT
Print Name: Signature: Date/Time:

EMPLOYEE HEALTH SERVICES FOLLOW-UP VISIT	
High Risk Final Evaluation Date (14 days post last exposure):	Temperature:
□ Workforce member continues to be asymptomatic	
□ Workforce member self-monitoring log submitted □No, reason:	
□ Workforce member symptomatic, contact EHS provider and referred to Primary Care Provider/IA Provider. Remove from work.	
□ Case closed, no evidence of disease	
COMMENTS	
EHS SIGNATURE FINAL VISIT	
Print Name: Signature: Date/Time:	

DEFINITIONS
Self- Monitoring means the WFM will monitor themselves for fever by taking their temperature twice a day and remain alert for covid like symptoms. If WFM develops symptoms, you must notify Employee Health and/or your healthcare provider. Recommend advance notice to your healthcare provider prior to further evaluation.

Last Name:	First Name:	Birthdate:		Employee#/C#:
Job Classification:	Item:	Work Facility:	Dept#/PL:	Dept/Division:
Email Address:	Work Phone:	Supervisor's Name:		

You have been identified to self-monitor for signs and symptoms of respiratory illness. You are responsible for monitoring yourself for symptoms. This tool was developed to assist you with this effort. If you think you have a respiratory infection, stay home, except to get medical care.

- **If your temperature is greater than 100.0°F (37.8°C) and/or you develop a cough with shortness of breath or other signs of illness,** you can either contact Employee Health Services or your healthcare provider

☐ You are required to return this log to Employee Health prior to returning to work

☐ You are not required to return this log to Employee Health

Day # (from last contact)	1		2		3		4		5		6		7	
Date														
AM or PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature														
Cough	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Difficulty breathing/shortness of breath	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Chills or repeated shaking with chills	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Muscle pain	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Headache	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Sore throat	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
New loss of taste or smell	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Fever/Pain Reducers [1]	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Take your temperature daily and write it down. Mark if you have any of the symptoms: circle 'Y' for Yes and 'N' for No. **Don't leave any spaces blank**. If you have a fever or any symptom, immediately call either Employee Health or your healthcare provider.

Day # (from last contact)	8		9		10		11		12		13		14	
Date														
AM or PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature														
Cough	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Difficulty breathing/shortness of breath	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Chills or repeated shaking with chills	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Muscle pain	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Headache	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Sore throat	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
New loss of taste or smell	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Fever/Pain Reducers [1]	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N

COMMENTS:_____
_____

For any questions or concerns contact your Employee Health Representative at _____.

1: Aspirin, Tylenol® (acetaminophen), or MOTRIN® (ibuprofen). If Yes, please indicate medication in Additional Notes section