REQUEST TO TEST SOURCE
for notification to a public safety worker (PSW)* of a possible communicable disease exposure
* [peace officer, detention services officer, firefighter, EMS employee, or other volunteer emergency responder]

1 Exposed
   event date/time          name          badge/employee #
   work address            work phone #      best phone #
   employer                supervisor       email

2 Event
   Inhalation of aerosolized particles or droplets
       ☐ mouth to mouth       ☐ intubation
       ☐ throat exam          ☐ suctioning

   Percutaneous, Conjunctival, or Mucosal contact
       ☐ Splash: ☐ non-intact skin | ☐ eyes | ☐ nose | ☐ mouth
       ☐ blood | ☐ other body fluid:
       ☐ needlestick/sharp injury | ☐ bite

Site, extent, duration of fluid exchange:


3 Source
   name          DOB
   address       phone

4 Recipient
   nurse/clinician     hospital

▲ requestor legibly completes & leaves with health care provider | HCP completes below & informs health dept. of result ▼

Charge nurse: Please facilitate the collection of an appropriate test panel, based on the indicated exposure, and deliver form to infection prevention or employee/occupational health for notification. This form is not for patient chart, and no private health information may be released to the exposed.

The undersigned has
☐ called report to DCHHS at (214) 819-2004
☐ faxed completed form with lab reports to (214) 819-6095
☐ if TB+, faxed form & report to (214) 819-2805

name          phone