



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]

requestor →

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	<input type="checkbox"/> mouth to mouth	<input type="checkbox"/> intubation
	<input type="checkbox"/> throat exam	<input type="checkbox"/> suctioning
Percutaneous, Conjunctival, or Mucosal contact	<input type="checkbox"/> Splash: <input type="radio"/> non-intact skin <input type="radio"/> eyes <input type="radio"/> nose <input type="radio"/> mouth <input type="radio"/> blood <input type="radio"/> other body fluid:	
	<input type="checkbox"/> needlestick/sharp injury	<input type="checkbox"/> bite

Site, extent, duration of fluid exchange:

③ **Source**

name	DOB
address	phone

④ **Recipient**

nurse/clinician	hospital
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▲ requestor *legibly* completes & leaves with health care provider | HCP completes below & informs health dept. of result ▼

hospital →

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
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lab	outcome	
RPR	-	+
HIV	-	+
Hep B	-	+
Hep C	-	+
TB	-	+
other	-	+