

**CONTRA COSTA HEALTH SERVICES-PUBLIC HEALTH
 NOTIFICATION OF POSSIBLE COMMUNICABLE DISEASE EXPOSURE
 (Complete all information below – PLEASE PRINT)**

PERSON POTENTIALLY EXPOSED	
Name:	Work Phone ()
Employer:	Home Phone ()
Employer address:	
<input type="checkbox"/> Completed hepatitis B vaccination series: <input type="checkbox"/> Partial hepatitis B series: <input type="checkbox"/> No hepatitis B vaccinations	
SOURCE PERSON FOR POTENTIAL EXPOSURE:	
Name:	Home phone: ()
Address:	
INCIDENT REPORT:	
Location of Incident:	Date of Incident:
	Time of Incident:
Person transported to:	Ambulance #
	Incident #
TYPE OF EXPOSURE:	
<input type="checkbox"/> Mouth to Mouth resuscitation – without protective device <input type="checkbox"/> Needle stick injury - with a used/non sterile needle <input type="checkbox"/> Blood or secretions splashed into → <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Wound <input type="checkbox"/> Meningitis <input type="checkbox"/> Close exposure to a person with TB → <input type="checkbox"/> Known TB <input type="checkbox"/> Suspected TB <input type="checkbox"/> Other risk exposure → Please describe _____	
Notify Public Health (925) 313-6740 during work hours M-F 8a-5p and Fax a copy of this form to (925) 313-6465. After hours and holidays leave a voice mail message at this same number. Public Health will follow-up with the designated officer and/or employee during normal work hours. For <u>urgent</u> consults phone (925) 313-6740 to connect with the on-call Health Officer.	
Precautions/equipment used during this exposure: <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Face shield <input type="checkbox"/> Eye protection <input type="checkbox"/> N95 mask <input type="checkbox"/> Other: _____	
How soon after the potential exposure were you able to cleanse the exposure site? _____	
Other information regarding exposure: _____	
Occupational Health Provider:	Address:
Name of person completing this form: PRINT	Phone
PUBLIC HEALTH FOLLOW UP:	
<input type="checkbox"/> No reportable communicable disease identified in source person	
<input type="checkbox"/> Recommendations given to: <input type="checkbox"/> Employee Date: _____ <input type="checkbox"/> Employer Date: _____	
Actions taken by Public Health:	
<input type="checkbox"/> EMS-7 mailed to: _____ By: _____ Date: _____ <input type="checkbox"/> Other actions: _____	
Public Health follow up by: Name:	Phone: ()