East Central Illinois EMS

Risk Screen

Agency/Person Involved: _____

Patient Name: _____

Date: _____ Time: _____

Please complete the proper information below. Sign, date, and return this form to the EMS Office via fax (217-359-7408) or email (Leslie.R.Mennenga@osfhealthcare.org).
This form is for Quality Improvement only. All information is confidential.

☐ Equipment or Vehicle Failure
☐ Delay in Response or Transport
☐ Injury to Patient or Damage to Property
☐ Interfacility Transfer Issue
☐ Policy/Protocol Deviation
☐ Significant Exposure*
☐ Quality of Care
☐ Other: _____

**Significant Exposure Information Only*

Meets the following significant exposure criteria as per Policy "Significant Exposure to Body Substances and/or Communicable Disease":

☐ Puncture of the skin with a contaminated needle or other sharps.
☐ Direct contact of the patient's body fluids with the provider's mucous membranes.
☐ Patient's body fluids in contact with the provider's non-intact skin
☐ Exposure to one of the diseases listed in the policy "Exposure to Communicable Disease Notification"

The following Personal Protective Equipment was used (mark all that apply):

☐ gloves ☐ eye protection ☐ mask
☐ gown ☐ N-95 Respirator

Initial treatment received from _____.
(name of hospital, ED or Occ Med, physician office)

Follow-up instructions received ☐ YES ☐ NO

Describe the incident below. Please include only the facts surrounding the incident. Do not include opinions of what happened or should have happened. If additional space is required, please attach a separate sheet.

Person completing Risk Screen (print name): _____

Signature: _____ Date: _____

Contact email (for follow-up):_____