EMPLOYEE INFECTION REPORT

Please e-mail your completed report to QAPI@activehomehealthcare.com

Date/Time of Report

Section A.

EMPLOYEE INFORMATION	Name (First, Middle, Last)	Occupation or Job Title

INFECTION REPORT

Date of Onset

Status *(mark all that apply)*:
- ☐ Active Disease
  - ☐ Confirmed
  - ☐ Suspected
- ☐ Admitted to hospital
- ☐ At home

Suspected or Confirmed Exposure Setting:
- ☐ At home
- ☐ Healthcare Facility
- ☐ Patient Residence
- ☐ Agency Office
- ☐ Other: _____
- ☐ Unsure

Suspected/Actual Site of Infection:
- ☐ Oral
- ☐ Skin
- ☐ Respiratory
- ☐ Wound
- ☐ Post Op Wound
- ☐ Gastrointestinal
- ☐ Urinary
- ☐ Blood
- ☐ Other: _____
- ☐ I do not wish to answer

Sign/Symptoms *(mark all that apply)*:
- ☐ Asymptomatic
- ☐ Sore Throat
- ☐ Rashes
- ☐ Other: _____
- ☐ Coughing
- ☐ Itchiness
- ☐ Headache
- ☐ Sneezing
- ☐ Dizziness
- ☐ Erythema
- ☐ I do not wish to answer
- ☐ Congestion
- ☐ Fever
- ☐ Dyspnea
- ☐ Runny Nose
- ☐ Chills
- ☐ Purulent drainage/Increased wound drainage

Has physician been notified? ☐ Yes (please complete **Section B**) ☐ No, will not visit. ☐ No, plan to visit.

Section B.

Date of Diagnosis

☐ Section does not apply to me

TREATMENT INFORMATION
- ☐ Received treatment:
  - ☐ Began (mm/dd/yyyy): _____
  - ☐ Ongoing
  - ☐ Ended (mm/dd/yyyy):_____
- ☐ Drug resistance suspected
- ☐ Untreated:
  - ☐ Will treat
  - ☐ Refused treatment
  - ☐ Other: _____

TRANSMISSION INFORMATION

A. Did physician declare infection to be transmittable?
- ☐ Yes
- ☐ No
- ☐ Unsure

B. (*If answered yes to A,*) Have you been cleared to return to the healthcare setting, make contact with patients, etc.?
- ☐ Yes
- ☐ Not yet

An employee's return to work will be in accordance with Active Home Health Agency policy and with the permission of the employee's physician. The agency requires a physician's note when employees are out sick for three (3) days or more. However, when employees take time off from work due to flu-like symptoms during a declared pandemic health crisis, Active Home Health Care requires a medical certification and that they are able to perform the essential functions of the job with or without reasonable accommodation. This requirement will only be upheld if there is a reasonable belief that the employee's present medical condition would pose a direct threat to safety in the workplace. Active Home Health will not discriminate based on your medical condition or medical history. During a pandemic, Active Home Health Care employees are encouraged to inform the company of any infectious disease that they may have. This will allow us to take all necessary precautions and protect co-workers and our clients. All information related to your medical condition will be kept in strict confidence in accordance with the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA).

Employee Signature: _____ Date: _____

Received Report by: _____ Date: _____