



# Retrospective Assessment Tool for Healthcare Personnel Potentially Exposed to COVID-19 (Updated 7/30/20)

**Directions:** For each confirmed COVID-19 case, maintain a line list of healthcare personnel (HCP) and complete a tracking form for each potentially exposed HCP (e.g., nurses, physicians, respiratory therapists, environmental services, others). Upon completion, please refer to ***NJDOH Healthcare Personnel Exposure to Confirmed COVID-19 Case Risk Algorithm*** to determine if the HCP should be excluded from work. Use additional sheets if necessary. The overall risk level should be determined from the highest risk level of all dates exposed. If work exclusion is indicated, exclusion should begin on the most recent date relative to the exposure and continue for 14 days as per CDC and NJDOH guidance.

PLEASE NOTE: This form is designed for retrospective assessment of potential exposures. For current or ongoing HCP exposures, please refer to the ***NJDOH Healthcare Personnel (HCP) COVID-19 Exposure Checklist***.

<b>Case ID:</b>			
<b>Employee ID:</b>		<b>Facility Name:</b>	
<b>Name:</b>		<b>Sex:</b>	
<b>Address (street, city, county, state):</b>		<b>Age (Years):</b>	
<b>Phone Number(s):</b>		<b>Employee Position:</b>	

Determination:  Exclude from work     No work restrictions

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

		Dates the COVID-19 case was in the facility: Please enter Y (yes) or N (no) in each box based on the exposure question and the date specified.				Please describe any exposures requested in this column here. Please use a separate sheet of paper if you need more space.
Date/Shift		__/__/__	__/__/__	__/__/__	__/__/__	<b>Notes:</b>
1	Did you work a shift on this day? (Y/N) If NO, STOP for this date					
2	If yes, was this shift overnight? (Y/N)					
<b>EXPOSURE QUESTIONS:</b>						
3	Were you present in the room for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g. cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, manual ventilation, suctioning of airways, high flow oxygen delivery, nebulizer therapy, or sputum induction)? (Y/N)  If yes, list which procedures in notes column and SKIP to question 9					
4	Did you have PROLONGED CLOSE CONTACT with a COVID-19 case, e.g., patient, visitor, HCP (i.e., within 6 feet for over 10 minutes)? (Y/N)					
5	Did you have contact with a COVID-19 case's secretions or excretions (Y/N)?  If yes, please indicate if secretions/excretions contacted unprotected mouth, eyes, nose or hands in notes column.					
<b>PERSONAL PROTECTIVE EQUIPMENT AND HAND HYGIENE QUESTIONS:</b>						
6	Were you wearing gloves (Y/N)					
7	Were you wearing a gown (Y/N)					
8	Were you wearing a N95 or equivalent or higher-level respirator (Y/N)					
9	Were you wearing a mask (Y/N)					
10	Were you wearing eye protection such as goggles or disposable face shield (Y/N)					
11	Was the patient wearing a facemask? (Y/N)					
Exclude from work criteria met?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Adoption of Strategies to Mitigate Healthcare Personnel Staffing Shortages adopted:  Yes  No

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>