GREY-BRUCE DESIGNATED OFFICER TASKFORCE

DESIGNATED OFFICER INCIDENT EXPOSURE REPORT

Please note that if the exposed person is wishing to pursue the Mandatory Blood Testing Act Form 1 and Form 2 must be completed and submitted to the health unit within 7 days of exposure. Forms are found at: Ontario Central Forms Repository - Form Search Results (gov.on.ca)

General Information

Name of Exposed Person: _____ DOB: _____ Phone: _____
YYYY/MM/DD

Family Physician of Exposed Person: _____

Name of Designated Officer: _____ Organization: _____ Phone: _____

Section 1 – Exposure Information

Body Fluid Exposed to:

☐ Blood ☐ Vomitus ☐ Urine/Feces ☐ Wound Drainage ☐ Saliva/Droplet ☐ Other _____

How long was the contact/exposure? _____

Exposure:

☐ Needle stick/puncture by a sharp object.
- Visible blood on object: ☐ Yes ☐ No

☐ Splashed:
- ☐ Mouth
- ☐ Eye

☐ Laceration to the skin
☐ Non-intact skin exposed to blood/body fluid
☐ Close contact with someone with cough and/or fever
☐ Close contact with someone with suspected infectious disease
☐ Mouth to mouth resuscitation without barrier device
☐ Human, animal or insect bite.

Is the skin broken? ☐ Yes ☐ No Did the biter have blood in mouth? ☐ Yes ☐ No

☐ Other: (Describe in detail) _____

Personal Protective Equipment Worn During Incident (Check all that applies):

☐ Goggles ☐ Gloves, type _____ ☐ Surgical Mask
☐ Protective Clothing, type _____ ☐ N95
☐ Other, describe in detail _____

Was the PPE intact? e.g. were the gloves torn? Did any body fluids soak through the protective clothing? ☐ Yes ☐ No

If no, describe _____

Additional Information - What other information is available that will help assess the risk of exposure? *(e.g. suspected diagnosis of the source person, location of the exposure (high risk location), animal shelter or place with pets)*

_____

_____

_____

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Section 2 – Emergency Services Worker's Immune Status

☐ *Tetanus & Diphtheria* (every 10 yrs): _____ (YYYY/MM/DD) ☐ *Annual Influenza:* _____ (YYYY/MM/DD)

☐ *Measles, mumps, rubella* (MMR) **Dates, if applicable:** #1 _____ #2 _____

☐ *Varicella* (Chicken Pox)

☐ Has ESW received a full course of *Hepatitis B* vaccine? ☐ Yes ☐ No Date of 3rd dose: _____

- Blood work done to check if immune? ☐ Yes ☐ No Result: _____
- Date immunity status checked: _____ (YYYY/MM/DD)

Section 3 – Source Information & Risk Transmission

Source Person's Name: _____ DOB: _____ (YYYY/MM/DD) Phone: _____

Address: _____ Postal Code: _____ Family Dr.: _____

1. Is the source of the transmission known? ☐ Yes ☐ No

2. History of source
   - ☐ Multiple blood transfusions prior to 1985
   - ☐ Haemophilia
   - ☐ Known / History of drug use
   - ☐ Tattoos / Piercings
   - ☐ From a country with high rates of infection
   - ☐ Person has an infectious disease, please specify: _____
   - ☐ Other: _____

Taken to hospital: ☐ Yes ☐ No

Hospital Name: _____ Date & Time: _____

Section 4 – Assessment by Designated Officer

Exposure occurred: ☐ Yes (if yes, notify the Grey Bruce Health Unit) ☐ No

Actions Taken:

_____

_____

_____

_____

Reported to Public Health (519-376-9420 ext 6; after hours 519-376-5420; fax 519-376-4152):

Name (please print): _____ Date: _____ Time: _____

Exposure Report Completed By:

Name (please print): _____ Signature: _____

Emergency Service: _____ Date: _____

DESIGNATED OFFICER INCIDENT EXPOSURE REPORT

Emergency Worker Report

CONFIDENTIAL WHEN COMPLETE

Emergency Service Worker Information

Last Name: _____ First Name: _____ DOB: _____
yr/mo/day

Address: _____

Phone Number: _____ Family Physician: _____

Date of Incident: _____ Time: _____

Description of Incident

_____

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_____ _____
ESW Signature Designated Officer Signature

_____ _____
Date Date