Appendix 3 –Exposure Incident Report Form

Please see the following pages for the Exposure Incident Report Form.

EXPOSURE INCIDENT REPORT FORM

Copy to Family Physician and Regional Medical Health Officer.
(Regional MHO will forward to Employee Health or FNIHB/ NITHA as appropriate)

	Exposure	Physician Assessment
Date (yyyy/mm/dd)		
Time		
Location		ER □ Office □

Complete Form if: The fluid the person was exposed to is capable of transmitting blood borne pathogens **AND** the fluid contacted the exposed person in such a way that would allow for transmission of blood borne pathogens.

A. EXPOSED INDIVIDUAL (enter dates as yyyy/mm/dd)		
Name		DOB ____/_____/____ □ Female □ Male
Address (name of First Nations reserve if living on reserve)		Home phone number _____ Cell phone number _____ Work phone number _____
Health Card Number		Primary Care Provider (MD/RN(NP)/none)

EXPOSED INDIVIDUAL'S PREVIOUS HISTORY (enter dates as yyyy/mm/dd)		
Prior Hepatitis B vaccination If yes, specify number of doses (please circle)	□ No □ Yes □ Unknown 1 2 3 other _____ Date: _____	
Hepatitis B surface antibody immune (Anti-HBs ≥10 IU/L)	□ No □ Yes Date: □ Unknown	
Prior Hepatitis B surface antigen (HBsAg) status	□ Positive □ Negative Date: _____	□ Unknown
Prior Hepatitis C antibody status (anti-HCV)	□ Positive □ Negative Date: _____	□ Unknown
Prior HIV antibody status (anti-HIV)	□ Positive □ Negative Date: _____	□ Unknown
Previous PEP kit usage	□ No □ Yes Date: □ Unknown	

B. DETAILS OF EXPOSURE

*** In the event of a reciprocal exposure, complete form for both individuals**

1. Type of Exposure and Injury

Exposure Setting:	□ Occupational Employer:	□ Non-Occupational (Community) □ Lifestyle □ Sexual Assault	
Type of Exposure:	□ Percutaneous □ Mucous membrane □ Bite	□ Insertive Penile-Anal intercourse □ Receptive Penile-Anal intercourse □ Insertive Penile-Vaginal intercourse	□ Receptive Penile-Vaginal intercourse □ Non-intact skin exposure □ Other
Extent of Injury:	□ Trauma at site □ Deep injury	□ Fresh/visible blood on the device □ Direct injection into a vein or artery	□ Other

2. Type of Source Fluid

□	Blood, serum, plasma or other biological fluids visibly contaminated with blood
□	Pleural, amniotic, pericardial, peritoneal, synovial and cerebrospinal fluids
□	Semen, vaginal secretions
□	Saliva contaminated with blood
□	Saliva not contaminated with blood
□	Lab specimens containing concentrated HBV, HCV, or HIV
□	Organ and tissue transplants
□	Breast milk
□	Unknown (e.g., needle found on street)
Other (describe)	_____

C. SOURCE INDIVIDUAL(complete below)

□ Unknown □ Known (first two letters of the first and last names and Date of Birth)

Initials ____ ____ DOB (yyyy/mm/dd) _____/_____/_____

SOURCE INDIVIDUAL'S PREVIOUS HISTORY (enter dates as yyyy/mm/dd)		
Prior Hep B vaccination If yes, specify number of doses (please circle)	□ No □ Yes □ Unknown 1 2 3 other _____ Date: _____	
Hepatitis B surface antibody immune (Anti-HBs ≥10IU/L)	□ No □ Yes Date: unknown	
Prior Hepatitis B surface antigen (HBsAg) status	□ Positive □ Negative Date: _____	□ Unknown
Prior Hepatitis C antibody status (anti-HCV)	□ Positive □ Negative Date: _____	□ Unknown
If HCV antibody positive, HCV PCR status	□ Positive □ Negative Date: _____	□ Unknown
Prior HIV antibody status (anti-HIV)	□ Positive □ Negative Date: _____	□ Unknown
Family Physician &/or Infectious Disease Specialist		
If known HIV positive:	CD4 Count: _____ Viral Load: _____ Current ARV Treatment: _____	
HIV POC Test Date:_____	**Result: □ Reactive □ Non-reactive □ Indeterminate**	

RISK ASSESSMENT OF SOURCE IF HIV NEGATIVE OR UNKNOWN		
Consideration of risk is based on source's IV drug use, participation in high-risk sexual practices, hepatitis C status, and if he or she is from an HIV endemic country. **Refer to Section 2 – Risk Assessment and Appendix 14 – Source Patient Risk Assessment**	**Indicate if assessment of source risk is considered to be High or Low**	
	High	**Low**

D. Baseline Blood Test results

If the baseline test results are not be available on the day of the exposure, the physician or RN(NP) providing follow-up may complete the following later, and will also decide regarding further follow-up testing as per Appendix 10.

SOURCE'S BASELINE RESULTS	**□ Not available for testing**
Hepatitis B surface Antigen (HBsAg)	□ Positive □ Negative
Hepatitis C antibody (anti-HCV)	□ Positive □ Negative
HIV antibody (anti-HIV)	□ Positive □ Negative

EXPOSED BASELINE RESULTS	
Hepatitis B surface antibody (anti-HBs)	□ Present □ Absent
HIV antibody (anti-HIV)	□ Positive □ Negative
Hepatitis C antibody (anti-HCV)	□ Positive □ Negative
Hepatitis B surface antigen (HBsAg)	□ Positive □ Negative

NOTES/ADDITIONAL INFORMATION

Physician's Overall Assessment of Risk of HIV Transmission from Exposure

☐ **High** ☐ **Low**

Ideally, PEP should be administered within 2 hours.
It is not recommended if >72 hours since exposure.

To be completed by attending ER physician / RN(NP):

FOLLOW-UP PROVIDED AT TIME OF ASSESSMENT			
	Yes	**No**	**N/A**
PEP Kit Provided Date and Time of first dose _____			
Phone Consultation with ID Specialist(Identify)_____			
Ongoing PEP Prescription Provided			
Referral to other supportive services (i.e. Mental Health/Addictions)			
HBIg provided	DOSE		DATE
1st Dose of hepatitis B Immunization Given	DOSE		DATE
STI Testing/Treatment (identify Tx given)_____			
Td Vaccine provided	DOSE		DATE
Tetanus Immune Globulin provided	DOSE		DATE
Discussion about follow-up blood work			
Faxed to Regional MHO (Do not await baseline test results before faxing) pages 1, 2, 3, 4 & 5			
Form faxed to ID Specialist when consult is required, pages 1, 2, 3 & 4			
Form faxed to Exposed Family Physician (pages 1, 2, 3, & 4)			

Completed by: _____ Date: _____

To be completed by public health or occupational health nurse providing follow-up:

PUBLIC HEALTH OR OCCUPATIONAL HEALTH FOLLOW-UP			
	Yes	**No**	**N/A**
Exposed Individual Contacted			
Form faxed to RHA Occupational/Employee Health Department			
Form faxed to FNIHB/NITHA for individuals living on reserve			
Verified prescription filled (if prescribed)			
Referral to other supportive services (i.e. Mental Health/Addictions)			
Discussion about follow-up blood work			
Risk reduction counselling provided			

Completed by: _____ Date: _____

SOURCE INDIVIDUAL		
Name		DOB ____/_____/____ □ Female □ Male
Address	If inpatient, Room # _____	Home phone number _____ Cell phone number _____ Work phone number _____
Health Card Number		Family Physician

Unless the source provides consent, this page should only be faxed to the MHO. Refer to Appendix 15 – Collection Use and Disclosure of Information. If in the professional opinion of the attending physician, the ID Specialist requires the source's identifying information, and consent has not been provided, documentation of the rationale should be included.

Source identifying information should be severed from the exposed person's health record.

Consent obtained to share identifying information with ID Specialist

□ Yes □ No

Information Faxed:

Date Faxed to ID Specialist _____

Additional comments: _____

_____

_____

_____

Signature _____