

Occupational Exposure Report Form



Health Facility / Address.....

A.) Exposed patient information:

Date of Injury: _____ Time of Injury: _____

Ward or other place of injury: _____

Name of injured staff: _____

Position/Designation: _____

B.) Source patient information:

Name of patient involved in incident: _____

Age: _____ Gender: _____ Case File Number: _____

Medical Diagnoses of Patient: _____

HIV status of patient: _____ If Unknown, Date of HIV test: _____

Hepatitis B status of patient: _____ If unknown, date of Hepatitis B test? _____

Hepatitis C status of patient: _____ If unknown, date of Hepatitis C test? _____

C.) Circumstances of injury:

Type of injury: (Was this a percutaneous (through the skin), mucosal injury (i.e. splash in eye), or cutaneous (i.e. exposure to intact skin injury)?

If percutaneous injury:

Was it subcutaneous or intramuscular? _____ Depth of injury? _____

What was the size of the needle? _____ Was blood drawn? _____

Was it a solid needle or a hollow-bore needle? _____

If mucosal/ cutaneous injury: What was volume of infectious fluid (small, e.g. drops or large, e.g. a major splash)? _____

If patient was known to be HIV positive:

Any indication if early or late stage HIV infection? _____

Was patient on ARV therapy? _____

What was last CD4 count? _____

Were gloves/ protective barriers worn? Yes / No

Any Witnesses to Injury? _____

Injury reported to: _____

D.) Provision of PEP:

PEP Counseling performed: Yes / No By whom? _____

Did injured worker consent to an HIV test? Yes / No

If NO, state reasons: _____

If YES, Date of initial HIV test: _____ Date of final test: _____

Hepatitis B status of injured worker: _____

Received Hepatitis B Vaccines in past? Yes / No

Date of initial Hepatitis B test: _____ Result: __ Date of final test: _____ Result: __

Date of initial Hepatitis C test: _____ Result: __ Date of final test: _____ Result: __

PEP Regimen: _____

Remarks (including adverse reactions during duration of PEP):

E.) (Confirming that the above information is accurate)

Signature of Injured Worker: _____

Name of person completing this form: _____