

DESIGNATED OFFICER INCIDENT EXPOSURE REPORT

Emergency Services Worker		Incident/Call #:				
Name:	Sex: □ M □ F	DOB:				
Address:	Postal Code:	Phone:				
Date of Exposure:	Time: Family Physician:					
Section 1 – Exposure Information						
Describer	narp object. Visible blood on object					
☐ Splashed in the eye by	Tune and solution amount of hads fluid					
$\ \square$ Splashed in the mouth by	ed in the eye by					
\Box Laceration to the skin by	Type and relative amount of body fluid Laceration to the skin by Type and relative amount of body fluid					
☐ Non-intact skin exposed to	Type and relative amount of body fluid Non-intact skin exposed to					
□ Non-intact skin exposed to Describe approximate size of area of non-intact skin and relative amount of body fluid □ Close contact with someone with cough, possible TB.						
☐ Close contact with suspected meningococcal disease.						
☐ Confined in a closed area (vehicle, aircraft) with someone who was coughing. Length of time:						
☐ Mouth to mouth resuscitation without barrier device.						
Human, animal or insect bite. Is the skin broken? □ Yes □ No □ Other: (Describe in detail)						
How long was the contact/exposure? (E.g. the worker was soaked with [type of fluid] for at least [time] before washing it off).						
Personal Protective Equipment Worn during Incident (Check all that applies)						
Protective Clothing, type	☐ Goggles☐ Gloves, type☐ Protective Clothing, type☐ N95					
☐ Other, describe in detail						
Section 2 – Emergency Services Worker's Immune Status						
☐ <i>Tetanus & Diphtheria</i> (every 1 Date of most recent		iluenza ost recent				
☐ <i>Measles, mumps, rubella</i> (MMR) If born after 1970 and no history of having had measles or mumps, should have 2 doses of MMR given at least one month apart. Not to be given in pregnancy. Dates, if applicable #1 #2 Comment:						
 □ Varicella (Chicken Pox) ESW should be immune to chicken pox, either through vaccination or previous disease. □ Vaccine not to be given in pregnancy. □ Comment:						
	epatitis B vaccine? ☐ Yes ☐ No Date					



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	Section 3 –	Source Inform	nation & Risk	ransmission	
1. Is the source of the	transmission kno	own? □ Yes	s □ No	If no, p	proceed to Section 4
2. History of source	☐ Known drug	g user. Injection, intry with high ra	snort, etc. tes of infection	☐ Haemophilia☐ Tattoos, boo	dy piercings
3. Source material kno	wn to contain	•	(HBC) □ Henune Virus (HIV	epatitis C (HBC)	
Taken to hospital: If yes, hospital Name:				Date & Time	9:
					·
Section 4 – Addition What other information the exposure, such as a met	is available that	will help assess	the exposure?	(E.g. suspected diag entally challenged, ar	nosis of the contact, location of nimal shelter or place with pets)
Section 5 – Actions Taken/Recommendations					
Was the incident Re	eported to Pub	olic Health (70	5-721-7520; aft	er hours 888-22	5-7851)? □ Yes □ No
Name (please print): Recommendations pro					
If Relevant, was the ES	W made aware o	of the Mandator	ry Blood Testing	; Act (2006)?	☐ Yes ☐ No
		xposure Repo	-	-	
Name (please print):					
Emergency Service:			Date:		



DESIGNATED OFFICER INCIDENT EXPOSURE REPORT

INCIDENT EXPOSURE REPORT Emergency Worker Report CONFIDENTIAL WHEN COMPLETE

Name of Emergency Service:		
Last Name:	First Name:	DOB:
Address:		yr./mo./day
Phone Number:	Family Physicia	n:
Date of Incident:	Time:	Incident/Call#:
Description of Incident:		
ESW Signature		Designated Officer Signature
Date		Date