

DESIGNATED OFFICER INCIDENT EXPOSURE REPORT

Emergency Services Worker		Incident/Call #:
Name: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____
Address: _____		<small>YR./MO./DAY</small>
Postal Code: _____		Phone: _____
Date of Exposure: _____	Time: _____	Family Physician: _____

Section 1 – Exposure Information

- Needle stick/puncture by a sharp object. Visible blood on object: Yes No
Describe: _____
- Splashed in the eye by _____
Type and relative amount of body fluid
- Splashed in the mouth 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 _____
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 Did the biter have blood in mouth? 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)

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

Section 2 – Emergency Services Worker’s Immune Status

- Tetanus & Diphtheria* (every 10 yrs.) *Annual Influenza*
Date of most recent _____ Date of most recent _____
- Measles, mumps, rubella* (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: _____

Has ESW received a full course of *Hepatitis B* vaccine? Yes No Date of last dose _____
Blood work done to check if immune? Yes No Date: _____ Result _____

