Services de santé du TIMISKAMING Health Unit

DESIGNATED OFFICER INCIDENT EXPOSURE REPORT

EMERGENCY SERVICES WORKER

Incident/Call #:

Name: _____ Sex: ☐ M ☐ F DOB: _____

Address: _____ P/Code: _____ Phone: _____

Date of Exposure: _____ Time: _____ Family Physician: _____

Reported to: _____ Time Reported: _____

NATURE OF OCCURRENCE/RISK ASSESSMENT

☐ Inadequate PPE for suspect/confirmed disease

☐ Close contact with someone with a cough and/or fever

☐ Close contact with someone with TB

☐ Relevant travel history ☐ Meningitis

☐ Human, animal or insect bite Is the skin broken? ☐ Yes ☐ No

☐ Needle stick/puncture with sharp object

☐ Intact skin exposed to hazardous chemicals

☐ Non-intact skin contact ☐ Splashed in eye

☐ Mouth to mouth resuscitation without barrier devise

Did the biter have blood in the mouth? ☐ Yes ☐ No

Bodily Fluids Exposed to: ☐ Saliva/Droplet ☐ Vomitus ☐ Wound drainage ☐Feces/Urine ☐Blood

How long was the contact/exposure? (e.g. The worker was soaked with [type of fluid] for at least [time] before washing it off).

_____

PPE/PREVENTION MEASURES

☐ Gloves	☐ Gown	☐ Safety Eyewear	☐ N95 respirator
☐ Tyvek Suit	☐ Face Shield	☐ Goggles	☐ FM 53 Mask
☐ Surgical Mask (patient)	☐ FLO2Max Mask	☐ Tychem	☐ C420 PAPR

Other PPE/Preventive Measures: _____

Did PPE barriers remain intact? ☐ Yes ☐ No If 'No', please describe failure: _____

If the employee did not use preventative measures, explain why? _____ or

☐ Information not provided to Paramedics Estimated duration of exposure (minutes): _____

EMERGENCY SERVICES WORKER'S IMMUNE STATUS

☐ Tetanus & Diphtheria (every 10 yrs) Date: _____ ☐ Annual Influenza Date: _____

☐ 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 3rd dose: _____

Blood work done to check if immune? ☐ Yes ☐ No Date: _____ Result: _____

DESIGNATED OFFICER INCIDENT EXPOSURE REPORT

SOURCE INFORMATION & RISK TRANSMISSION

1. Is the source of the transmission known? ☐ Yes ☐ No If 'No', proceed to 'Additional Information'

2. History of source
   - ☐ Multiple blood transfusion prior to 1985
   - ☐ Haemophilia
   - ☐ Known drug user.
   - ☐ Tattoos, body piercings
   - ☐ From a country with high rates of infection
   - ☐ Other: _____

3. Source material known to contain:
   - ☐ Hepatitis B (HBC)
   - ☐ Hepatitis C (HBC)
   - ☐ Human Immunodeficiency Virus (HIV)

Taken to hospital: ☐ Yes ☐ No If 'Yes', hospital: _____ Date/Time: _____

Source's Name: _____ DOB: _____ Phone: _____

Address: _____ P/Code: _____ Family Dr.: _____

ADDITIONAL INFORMATION

What other information is available that will help assess the exposure? (e.g. suspected diagnosis of the contact, location of the exposure).

ACTIONS TAKEN/RECOMMENDATIONS

REPORTED TO PUBLIC HEALTH (705-647-4305; after hours 705-647-3033)

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

Recommendations:

EXPOSURE REPORT COMPLETED BY:

Name (please print): _____ Signature: _____

Emergency Service: _____ Date: _____

DESIGNATED OFFICER INCIDENT EXPOSURE REPORT

EMERGENCY WORKER REPORT

Name of Emergency Service Organization: _____

Last Name: _____ First Name: _____ DOB: _____

Address: _____

Phone Number: _____ Family Physician: _____

Date of Incident: _____ Time: _____ Incident/Call #: _____

Description of Incident:

_____ _____

ESW Signature Designated Officer Signature

_____ _____

Date Date