



Health and Social Services
Yukon Communicable Disease Control

Blood & Body Fluid Exposure Form

Disclaimer: This information is being collected for the purposes of determining appropriate service.

A. Exposed Person (recipient of exposure) information				Date Form Initiated _____	
Name	D.O.B.	Age	Gender	M <input type="checkbox"/>	F <input type="checkbox"/>
Address	City/town	Province	Postal code	HCW	<input type="checkbox"/>
PHIS #	Contact phone #	Home	Work	Cell	Gen Public <input type="checkbox"/>
Reporting person	Health care facility				
					In-Patient <input type="checkbox"/>

B. History of exposure		
Date of exposure _____ <small>YYYY/MM/DD</small>	Time of exposure _____ <small>(24hr)</small>	Location of exposure _____

C. Type of exposure (check all that apply)	
Percutaneous injury (specify) <input type="checkbox"/> needlestick (specify type & gauge) _____ <input type="checkbox"/> cut by sharp object (type of instrument) specify instrument _____ <input type="checkbox"/> gloves worn <input type="checkbox"/> Bite - breaks the skin <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> Contact with exposed mucous membranes (specify) _____ <input type="checkbox"/> Contact with exposed non-intact skin (specify) _____ <input type="checkbox"/> (wound < 3 days) <input type="checkbox"/> cut skin <input type="checkbox"/> chapped/abraded skin Body site _____	Type of bodily fluid exposed to <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Plasma Bodily fluid substance visibly contaminated with blood (specify) _____ Other bodily fluid or substance (specify) _____

Description of circumstances surrounding the exposure (as provided by exposed person)	Examination of exposed person Findings related to the exposure including assessment of injuries (e.g. depth/type of injury).

D. History of Immunization & Serostatus of exposed person										
Immunization history	History	UNK	N	Y	Date of last test	Result				
Rec'd Hep B vaccination - dose 1	UNK	N	Y	Date	HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rec'd Hep B vaccination - dose 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rec'd Hep B vaccination - dose 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tetanus vaccination (date of last immunization)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
					Anti-HIV 1&2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

E. Information on source of blood and/or bodily fluid						
Name	D.O.B.	Age	Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	YHIS#
<input type="checkbox"/> Source risk factors unknown <input type="checkbox"/> Not considered high risk <input type="checkbox"/> High risk lifestyle or other concern for high risk (specify) _____ _____ See High Risk Page 25 of Guidelines	Status	UNK	N	Y	Date of last blood test	
	HIV +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	
	HBsAg +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	
	HCV +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	

F. Blood work testing of exposed & source person
 (mark *baseline* testing requisition "STAT" Indicate nature of STAT request on req. - Notify WGH Lab)
 F/U BW recommendations refer to page 12 of Guidelines

EXPOSED recommended blood tests	Baseline :		___ Wk Date:		___ Wk Date:		___ Wk Date:		___ Wk Date:	
	DUE		DUE		DUE		DUE		DUE	
	DONE		DONE		DONE		DONE		DONE	
	Baseline Results:		Results:		Results:		Results:		Results:	
HBsAg										
Anti-HBc										
Anti-HBs										
Anti-HCV										
Anti-HIV 1&2										

SOURCE blood tests	Date Draw n	Results	Lab results to be sent to:		Name
			Source person	Exposed person	
HBsAg			Source person's follow -up Health Care Provider: Yukon Communicable Disease Control	Exposed person's Follow -up to Health Care Provider: Yukon Communicable Disease Control	
Anti-HBc					
Anti-HBs					
Anti-HCV					
Anti-HIV 1&2					

G. Counseling

Exposed person has been counseled as outlined in Yukon Blood & Body fluid Exposure Guidelines (see page 28)

yes no (specify reason) _____

H. Recommendations for Management of exposed person

Recommendations

Consult with: BCCFE MOH YCDC Other _____

I. Post-exposure prophylaxis of exposed person

	Date given
<input type="checkbox"/> Hep B vaccine (HBV) Dose# _____	_____
<input type="checkbox"/> Hep B immune globulin (HBIG)	_____
<input type="checkbox"/> HIV post-exposure Prophylaxis (5 day starter kit)	_____
<input type="checkbox"/> Tetanus Immunization	_____

J. Follow-up Plan:

Designated Follow -up Health Care Provider: _____ (CLINIC)	Phone # _____	FAX # _____
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The following will be required by Follow -up Health Care Provider:

- Further post exposure counseling (specify) _____
- Hepatitis B Vaccine (HBV) - further doses of HBV to complete 3 dose series (0.1, 6M Os) (Refer to YCDC, WHC, CHC)
- Other: _____

- HIV 5 day starter kit has been provided. Client must be assessed w/in 3 days. Determine need for remainder of one months supply of antiretroviral. Consult YCDC, MOH & BC Centre for Excellence HIV/AIDS.
- Follow -up Blood work as per section F.
- Baseline Lab results will be sent to you
- Please follow -up with the client for results.

Signature of Reporting Physician or RN

Name (printed)

Date YYYY/MM/DD

Copy to Follow-up Health Care Provider, Fax copy to YCDC (867) 667-8349, Original to stay in Chart