

This form is to be used as a guide for Designated Officers to perform an exposure assessment. If assistance is required from Public Health in assessing the exposure, please fax this form to 1-855-934-5463. **This form does not replace any internal Emergency Service organizational forms or WSIB forms.**

GENERAL INFORMATION	
Name of ESW:	DOB:
Position/Title:	Name of Emergency Service:
Home Address:	Telephone:
Family Doctor:	Telephone:
Date of Exposure:	
Name of Designated Officer:	Telephone:

**Note: If the exposed person wishes to pursue the Mandatory Blood Testing Act Form 1 and Form 2 must be fully completed and submitted to Wellington-Dufferin-Guelph Public Health within 30 calendar days of the exposure. Forms are located at Ministry of Health website: <https://www.ontario.ca/page/mandatory-blood-testing>**

SECTION 1. EXPOSURE INFORMATION			
Infectious disease of concern:	<input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown		
<b>Type of Exposure:</b> (check all that apply)	<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Saliva <input type="checkbox"/> Other:	<input type="checkbox"/> Faeces <input type="checkbox"/> Vomit <input type="checkbox"/> Coughing/Sneezing into Mucous Membranes	<input type="checkbox"/> Wound Drainage <input type="checkbox"/> Amniotic Fluid
<b>How did the exposure occur?</b> (check all that apply)			
<input type="checkbox"/> Inadequate or no PPE for suspect/confirmed disease	<input type="checkbox"/> Needle stick/puncture with a sharp object		
<input type="checkbox"/> Close contact with someone with a cough, fever, or rash	<input type="checkbox"/> Non-intact skin exposed to:		
<input type="checkbox"/> Spray/splash in eye	<input type="checkbox"/> Spray/splash in nose and/or mouth		
<input type="checkbox"/> Close contact with someone with an infectious disease	<input type="checkbox"/> Mouth to mouth resuscitation without barrier		
<input type="checkbox"/> Human/animal bite	Was skin broken:	Yes	No
	Did biter have blood in their mouth:	Yes	No
Other:			
<b>What was the length of contact/exposure?</b>			

**Details of exposure:**

**What PPE was worn at the time of the exposure? (check all that apply)**

Goggles	Gloves (type: _____ )	Gown/Protective clothing
Mouthpiece/One-way valve CPR mask	Mask – Surgical / N95 (circle one)	Other:
None (explain why)		

Was there a failure of PPE? (explain)

**SECTION 2. ESW IMMUNE STATUS**

**Hepatitis B Vaccine**

Date	Date	Date
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AND Laboratory Evidence of Immunity:

Date of Titre	Immune	Not Immune
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**Tetanus and Diphtheria (Td) Vaccine**      Date of last booster:

**Pertussis (whooping cough) Vaccine**      Date:

**Measles, Mumps, Rubella (MMR) Vaccine**      Date:      Date:

OR Laboratory Evidence of Immunity:

Measles: Date of Titre	Immune	Not Immune
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Mumps: Date of Titre	Immune	Not Immune
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Rubella: Date of Titre	Immune	Not Immune
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**Varicella (Chickenpox)**

Varicella: Date of Titre      Immune      Not Immune

**OR**

Vaccine:      Date:

Vaccine:      Date:

**Tuberculosis (TB) Status**

Did ESW have a 2-step TB skin test on employment?      Yes      No      Unknown

If yes, provide dates:      Result:      Date:

Result:      Date:

**SECTION 3. SOURCE INFORMATION (if applicable)**

<b>Is the source known? (if yes, complete the rest of this section)</b>		Yes	No
Name:		DOB:	
Address:		Telephone:	
Family Physician:		Telephone:	
<b>Risk Factors:</b>	Unknown	History of drug use	
	Tattoos/Piercings	History of blood transfusions prior to 1992	
	Haemophilia	Previous incarceration, lived in a shelter, homeless	
	Known to have hepatitis B, C or HIV	From a country with high rates of infection	
	Confirmed/Suspected medical diagnosis (e.g., meningitis, TB):		
	Has symptoms of illness:	Fever	Vomiting
		Diarrhea	Rash
		Cough	Open sores
		Other:	
	Other risk factors:		
<b>Was source taken to hospital?</b>	Yes	No	
If yes, name of hospital:			

**SECTION 4. DESIGNATED OFFICER ASSESSMENT**

<b>Exposure occurred:</b>	Yes (reported to Public Health)	No
<b>Designated Officer:</b>	<p>Advised ESW to seek medical attention</p> <p><b>Note: If exposure is bloodborne, ESW should be seen at nearest Emergency Department within 2 hours of exposure</b></p> <p>Public Health notified for advice about exposure and recommendations for follow up</p> <p>Advised ESW about testing procedures applicable to exposure (e.g., baseline blood testing for hepatitis B, C, HIV or TB skin testing)</p> <p>Reinforced disease prevention strategies and infection control procedures to prevent future exposures</p> <p>Reinforced disease prevention through up-to-date vaccination</p> <p>Provided education on:</p> <ul style="list-style-type: none"> <li>Personal infection control precautions the ESW should take, and time frames involved (relating to the specific disease of exposure)</li> <li>Signs and symptoms the ESW should monitor for and what to do if symptomatic</li> <li>Possible repeat testing required and time frames for additional testing</li> <li>Workplace policies regarding treatment, prophylaxis, cost of medications, etc.</li> </ul>	

**Additional Notes:**

Designated Officer Signature:

Date Recommendations Discussed with ESW:

ESW Signature:

*The information on this form is collected under the authority of the Health Protection and Promotion Act in accordance with the Municipal Freedom of Information and Protection of Privacy Act and the Personal Health Information Protection Act. This information will be used for the delivery of public health programs and services; the administration of the agency; and the maintenance of healthcare databases, registries and related research, in compliance with legal and regulatory requirements. Any questions about the collection of this information should be addressed to the Chief Privacy Officer at 1-800-265-7293 ext. 4330.*