PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

Emergency Service Worker (ESW) Infectious Disease Risk Assessment

Designated Officers may call Public Health to discuss risk assessments at 1-800-265-7293 ext. 4752 or 1-877-884-8653 (after hours)

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:
Name of Public Health Contact:	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 by confidential fax (1-855-934-5463) to Wellington-Dufferin-Guelph Public Health within 7 days of the exposure. Forms are located at Government of Ontario Central Forms Repository: https://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/?OpenDatabase&ENV=WWE

SECTION 1. EXPOSURE INFORMATION

Type of Exposure:

- ☐ Blood
- ☐ Faeces
- ☐ Wound Drainage
- ☐ Urine
- ☐ Vomit
- ☐ Saliva
- ☐ Amniotic Fluid
- ☐ Other:

How did the exposure occur? (check all that apply)

- ☐ Inadequate PPE for suspect/confirmed disease
- ☐ Needle stick/puncture with a sharp object
- ☐ Close contact with someone with a cough, fever, or rash
- ☐ Non-intact skin exposed to:
- ☐ Spray/splash in eye
- ☐ Spray/splash in nose and/or mouth
- ☐ Close contact with someone with an infectious disease
- ☐ Mouth to mouth resuscitation without barrier
- ☐ Human/animal bite — Was skin broken: — Did biter have blood in their mouth
- Other:

What was the length of contact/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

AND Laboratory Evidence of Immunity:

Date of Titre ☐ Immune ☐ Not Immune

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

Mumps: Date of Titre ☐ Immune ☐ Not Immune

Rubella: Date of Titre ☐ Immune ☐ Not Immune

Varicella (Chickenpox) Vaccine Date: Date:

Other Vaccines, if applicable to exposure (e.g., Meningococcal, Hepatitis A)

Vaccine: Date:

Vaccine Date:

Tuberculosis (TB) Status

Did ESW have a 2-step TB skin test on employment?

If yes, provide dates: Result: Date:

Result: Date:

SECTION 3. SOURCE INFORMATION (if applicable)

Is the source known? (if yes, complete the rest of this section)

Name: DOB:

Address: Telephone:

Family Physician: Telephone:

Risk Factors:

☐ Unknown
☐ Tattoos/Piercings
☐ Hemophila
☐ Known to have hepatitis B, C or HIV
☐ History of drug use
☐ History of blood transfusions prior to 1992
☐ Previous incarceration, lived in a shelter, homeless
☐ From a country with high rates of infection
☐ Confirmed/Suspected medical diagnosis (e.g., meningitis, TB):
☐ Has symptoms of illness: ☐ Fever ☐ Vomiting ☐ Diarrhea ☐ Rash

☐ Open sores ☐ Other:

☐ Other risk factors:

Was source taken to hospital?

If yes, name of hospital:

Was voluntary consent obtained from source to have blood tested and results released to the ESWs family physician?

SECTION 4. DESIGNATED OFFICER ASSESSMENT

Exposure occurred:

Designated Officer:

- ☐ Advised ESW to seek medical attention
  Note: If exposure is bloodborne, ESW should be seen at nearest Emergency Department within 2 hours of exposure
- ☐ Public Health notified for advice about exposure and recommendations for follow up
- ☐ Advised ESW about testing procedures applicable to exposure (e.g., baseline blood testing for hepatitis B, C, HIV or TB skin testing)
- ☐ Reinforced disease prevention strategies and infection control procedures to prevent future exposures
- ☐ Provided education on:
  - ☐ Personal infection control precautions the ESW should take, and time frames involved (specific to disease exposed to)
  - ☐ Signs and symptoms the ESW should monitor for and what to do if symptomatic
  - ☐ Possible repeat testing required and time frames for additional testing
  - ☐ Workplace policies regarding treatment, prophylaxis, cost of medications, etc.

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.