Emergency Service Workers
Infectious Disease Risk Assessment Form

A. General Information

Date of Report:

Name of ESW Exposed: _____ DOB: _____

Work Title/Position: _____

Home Address: _____ Telephone: _____

Family Doctor: _____ Telephone: _____

Date of Exposure: _____ Time of Exposure: _____

Name of Emergency Service Organization: _____

Name of Designated Officer: _____ Telephone: _____

Name of Public Health Contact: _____ Telephone: _____

Name of Hospital (if applicable): _____

Name of Infection Control Contact: _____ Telephone: _____

Will the ESW be making an application under the Mandatory Blood Testing Act? ☐ Yes ☐ No

Date application submitted to the Medical Officer of Health: _____

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

B. Exposure Details

1. What body fluid(s) was the ESW exposed to? (more than one box may apply)

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

2. How did the exposure occur? (more than one box may apply)

☐ Needle stick/punctured by sharp object
Describe: _____
Was there visible blood on the object? _____

☐ Laceration of the skin contaminated by _____
(type and relative amount of body fluid)

☐ Spray/splash in the eye with _____
(type and relative amount of body fluid)

☐ Spray/splash in the nose and/or mouth with _____
(type and relative amount of body fluid)

☐ Non-intact skin exposed to _____
(describe approximate size of area exposed and relative amount of body fluid)

☐ Close contact with someone with a cough, possibly TB

☐ Close mouth contact with someone suspected of having meningococcal disease

☐ Confined in an enclosed area (e.g., vehicle, aircraft) with someone who was coughing
Length of time: _____

☐ Giving mouth-to-mouth resuscitation to someone without protection

☐ Human or animal bite
Was the skin broken? ☐ Yes ☐ No Comments: _____
Did the biter have blood in his/her mouth? ☐ Yes ☐ No

☐ Other (describe in detail):

3. How long was the contact/exposure? (e.g., the ESW was in the same vehicle as the client for [*length of time*]; the worker was soaked with [*type of body fluid*] for at least [*length of time*] before washing it off:

4. What personal protective equipment (PPE) was being used/worn at the time of the exposure? (more than one box may apply)

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

5. Was there a failure of PPE? (e.g. Were the gloves torn? Did any body fluids soak through the protective clothing?)

_____

_____

_____

6. If the ESW did not use PPE, explain the situation:

_____

C. Source Information (if available)

Is the source known? ☐ Yes ☐ No (If yes, please complete demographics)

Name: _____ DOB: _____ Sex: _____

Address: _____ Telephone: _____

Family Physician: _____ Telephone: _____

Risk Factors (Check all that apply):

- ☐ Unknown
- ☐ Injection drug use (current or in the past); snorts drugs
- ☐ History of tattoos/piercing
- ☐ Known to have HIV, hepatitis B, C
- ☐ History of blood transfusions prior to 1992; known to have hemophilia
- ☐ Previous incarceration, lived in a shelter, homeless (current or in past)
- ☐ Resident of institution or group home
- ☐ High risk sexual behaviour (e.g., multiple sex partners, anal sex)
- ☐ Source has a confirmed or suspected medical diagnosis (e.g., meningitis, tuberculosis)
  Describe: _____
- ☐ Current symptoms:
  - ☐ Fever ☐ Vomiting ☐ Presence of rash or open sores/wounds
  - ☐ Diarrhea ☐ Cough ☐ Other: _____

Was the source taken to hospital? ☐ Yes ☐ No

Date: _____ Time: _____ Hospital Name: _____

Was voluntary consent obtained from source to have blood tested and results released to the ESW's family physician or attending ER physician? ☐ Yes ☐ No

Attending/Family Physician: _____ Telephone: _____

Results: _____

D. ESWs Immune Status

What is the ESWs immune status?

☐ Hepatitis B Vaccine

Has ESW completed a full course of Hepatitis B vaccine?

☐ Yes ☐ No ☐ Unknown # Doses Received: _____

Dates: #1 _____ #2 _____ #3 _____

Booster date (if applicable): _____

AND

Laboratory Evidence of Immunity

☐ Yes ☐ No ☐ Unknown

Date of Titre: _____ ☐ Immune ☐ Not Immune

☐ Tetanus and Diptheria (Td) Vaccine Date of last booster: _____

☐ Pertussis (whooping cough) Vaccine Date: _____

☐ Measles, Mumps and Rubella (MMR) Vaccine

Dates: #1: _____ #2: _____

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

Dates: #1: _____ #2: _____

OR

Laboratory Evidence of Immunity

Date of Titre: _____ ☐ Immune ☐ Not Immune

☐ Other vaccines, if applicable (e.g. Meningococcal, Hepatitis A)

Vaccine: _____ Date: _____

Vaccine: _____ Date: _____

Tuberculosis (TB) status

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

☐ Yes ☐ No ☐ Unknown

If yes, please provide dates:

Results: _____ Date: _____

Results: _____ Date: _____

E. Post Exposure Recommendations

Designated Officer:

- ☐ Advised ESW to seek medical assessment.
  Note: If exposure is bloodborne the ESW should be seen at nearest Emergency Department within 2 hours of exposure
- ☐ Medical Officer of Health or designate notified for advice about exposure and recommendations for follow up (as needed)
- ☐ Reviewed possible risks associated with exposure with ESW and recommendations for follow up
- ☐ Advised ESW about testing procedures applicable to exposure (e.g., baseline blood testing for hepatitis B, C, and HIV for a bloodborne exposure or TB skin testing for an exposure to tuberculosis)
- ☐ Provided education on:
  - ☐ Possible drug therapy or post exposure prophylaxis (PEP) if indicated by a physician (e.g., risk versus benefit, length of treatment/prophylaxis policy regarding covering costs of drugs, etc.)
  - ☐ 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
- ☐ Reinforced disease prevention strategies and infection control procedures to prevent future exposures

Other notes:

Name of Designated Officer: _____

Signature of Designated Officer: _____

Date Recommendations Discussed with ESW: _____

Signature of ESW: _____

Post Exposure Recommendations – Medical Officer of Health:

Date/Time reported to Medical Officer of Health: _____

Recommendations reviewed with Designated Officer by:

Name of Public Health Staff: _____

Date: _____

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 health-care 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. 2975.