Appendix 1

CONFIDENTIAL

RISK ASSESSMENT FORM FOR CLINICAL SHARPS INJURIES & EXPOSURE TO BODY FLUDIS – to be used by A&E and Occupational Health Staff

NAME: **D.O.B.** **OCCUPATION:**	**ADDDRESS OF GP:**
DATE OF INJURY: **TIME OF INJURY:** **DEPT/WARD OF INJURY:**	**DATE OF PRESENTATION:** **TIME OF PRESENTATION:**
TYPE OF INJURY: BODY SITE: DESCRIPTION: PUNCTURE [ ] LACERATION [ ] SPLASH [ ] SKIN BROKEN YES [ ] NO [ ] BLEEDING/BRUSING PRESENT: YES [ ] NO [ ] SITE CLEANED/IRRIGATED IMMEDIATELY YES [ ] NO [ ] HOLLOWBORE NEEDLE YES [ ] NO [ ] SIZE ….... IM/IV/INTRA-ARTERIAL (Circle one) SOLID NEEDLE/BLADE? YES [ ] NO [ ] BLOOD IN NEEDLE/SYRINGE YES [ ] NO [ ] NEEDLE SAFE DEVICE YES[ ] NO[ ] FRESH/OLD? (Circle one) HOW RECENTLY USED? …… ANY INOCULATION OF BODY FLUIDS INTO RECIPIENT AS A RESULT OF INJURY? YES [ ] NO [ ] HUMAN BITE? YES [ ] NO [ ] BLOOD/BODY FLUID SPLASH? YES [ ] NO [ ] QUANTITY? …….. ON BROKEN SKIN? YES [ ] NO [ ] ON MUCOUS MEMBRANES YES [ ] NO [ ] VISIBLE BLOOD IN FLUID? YES [ ] NO [ ]	PROTECTIVE BARRIERS: - GLOVES WORN YES [ ] NO [ ] - INOCULATION THROUGH CLOTHING YES [ ] NO [ ] - GOGGLES/VISOR WORN YES [ ] NO [ ] **STATUS OF RECIPIENT (INJURED PERSON)** HEPATITIS B VACCINATED YES [ ] NO [ ] If yes, WHEN ? …… HEPATITIS ANTIBODY LEVEL YES [ ] NO [ ] If yes, ABOVE OR BELOW 10m I.U/ml.? …… RISK OF PREGNANCY YES [ ] NO [ ] TETANUS STATUS ……..…… BASELINE SAMPLE TAKEN YES [ ] NO [ ] SOURCE OF BODY FLUID: KNOWN? YES [ ] NO [ ] AVAILABLE? YES [ ] NO [ ] REF NO / NAME:

Form completed and signed by: ……..

Designation / Title …… Date ……..

When staff attend Accident and Emergency out of hours, please fax this form to the relevant Occupational; Health Department and leave a message on their answer phone. CRH: Answer phone 2037 Fax: 2243

Appendix 2

RISK ASSESSMENT FORM (to be used by health professional obtaining consent, from the DONOR (SOURCE) of an incident involving exposure to BBVs, for blood to be tested.

DOB / Ref No / Name of Source of injury / exposure:
(Obtain consent from source of injury to supply this information) ……..……

Name of recipient of injury: ……

Department / Ward …… **Date:** ……..

RISK FACTORS

HEPATITIS STATUS UNKNOWN [ ] KNOWN [ ] Status if known ……

HIV STATUS UNKNOWN [ ] KNOWN [ ] Status if known ……

If HIV Positive history of antiretroviral treatment / drug resistance …….

HISTORY IV DRUG ABUSE	YES [ ] NO [ ]
SAME SEX PARTNERS	YES [ ] NO [ ]
SEX WITH ANY OF THE ABOVE	YES [ ] NO [ ]
SEX WORKER	YES [ ] NO [ ]
MEDICAL / DENTAL PROCEDURE OUTSIDE THE UK	YES [ ] NO [ ]
UNPROTECTED SEX	AFRICA [ ] FAR EAST [ ]

BLOOD DONOR YES [ ] NO [ ]

If yes, DATE OF LAST DONATION

REC'D BLOOD TRANSFUSION OUTISDE UK YES [ ] NO [ ]

CONSENT OBTAINED FROM SOURCE PATIENT TO TEST FOR:

HBV YES [ ] NO [ ] NOT APPLICABLE [ ]
HCV YES [ ] NO [ ] NOT APPLICABLE [ ]
HIV YES [ ] NO [ ] NOT APPLICABLE [ ]

CONSENT OBTAINED FROM SOURCE PATIENT TO SEND FORM TO:

OCCUPATIONAL HEALTH YES [ ] NO [ ]
GUM YES [ ] NO [ ]

CONSENT OBTAINED BY: ……

CONSENT OBTAINED FROM DONOR (SOURCE) PATIENT TO RECORD RESULTS IN NOTES

CONSENT OBTAINED FROM DONOR (SOURCE) PATIENT TO GIVE RESULTS TO INJURED PARTY

It is the responsibility of the injured person or his/her nurse manager to ensure that this information is received by the Occupational Health Nurse or the Accident & Emergency Triage Nurse, who should ensure that this form is attached to the main assessment form (appendix 1). If the donor (source) is seen in the ambulatory area of MAU, the practitioner assessing the patient must ensure Occupational Health receive a copy.

If donor (source) agrees could be stored in medical notes. If not either at GUM/ Occupational Health.