OHU/SIS-2a

SHARPS INJURY SURVEILLANCE
OCCUPATIONAL HEALTH UNIT
MINISTRY OF HEALTH

"Rakan Anda Dalam Meningkatkan Kesihatan Pekerja"
"Your Partner In Enhancing Workers Health"

MANAGEMENT OF THE EXPOSED HEALTH CARE WORKER SECTION (OHU/SIS-2a)

OHU/SIS-2a : Risk assessment of disease transmission following sharps injury

PARTICULARS OF EXPOSED HEALTH CARE WORKERS

(Please tick (✓) where applicable)

1. Name : .....

2. Gender : Male : ☐ Female : ☐

3. NRIC : New : ☐☐☐☐☐☐ ☐☐ ☐☐☐☐
   Old : ☐☐☐☐☐☐☐☐

4. Nationality : .....

5. Age on the 1st of January : ☐☐ Years

6. Department presently attached to : .....

7. Contact number : .....

8. Date of injury : month ☐☐ day ☐☐ year ☐☐
   Time : ..... *am / pm

9. Date of first reporting to Medical / ID Team : month ☐☐ day ☐☐ year ☐☐
   Time : ..... *am / pm

10. Duration of employment in Ministry of Health : ☐☐ *month (s) / Year (s)

11. Duration of work in handling sharps : ☐☐ *month (s) / Year (s)

(*) delete where is not applicable

1. RISK ASSESSMENT OF THE INJURY (Please tick (✓) where applicable)

1.1 Type of injury / exposure:

1.1.1 Mucous membrane / skin integrity compromised: ☐

- Large Volume ☐
  (e.g. several drops, major blood splash and / or longer duration i.e. several minutes or more)
- Small Volume (e.g. few drops. short duration) ☐

1.1.2 Intact skin:

- Yes ☐
- No ☐

1.1.3 Percutaneous exposure:

- More Severe (e.g. large-bore hollow needle, deep puncture, visible blood on device, or needle used in sourse patient's artery or vein) ☐
- Less Severe (e.g. solid needle, superficial scratch) ☐

1.2 If the injury was to the hands, did the sharp item penetrate:

- Double pair of gloves ☐
- Single pair of gloves ☐
- No gloves ☐

2. RISK ASSESSMENT OF THE SOURCE (Please tick (✓) where applicable)

2.1 Source:

Known (Proceed to Q.2.2-2.10) ☐

Unknown (Proceed to Q.3) ☐

2.2 Name: .....

2.3 NRIC No: .....

2.4 Ward / Clinic: .....

2.5 Admitted / Walk-in for: .....

»2.6 Risk factors (if any):

- IVDU ☐
- Had unprotected sex ☐
- Blood products recipient ☐
- Elevated liver enzymes ☐
- Dialysis ☐
- Others : ☐

2.7 If source patient known but not tested, what is the reason?

.....

2.8 For HIV infected source patient.

2.8.1 On antiviral treatment:

- Yes ☐
- No ☐

2.8.2 If yes (on antiviral treatment):

2.8.2.1 • Drugs used (current) : .....

2.8.2.2 • Drugs used in the past : .....

2.8.2.3 • Latest viral load : .....

»2.9 Results of tests: (Please tick (✓) where applicable)

Pathogen	Test	Result	Date & Time drawn
HIV	Anti-HIV	☐ Positive ☐ Negative ☐ Not Tested	☐☐ Day ☐☐ Month ☐☐ Year Time : .....
Hepatitis B	HBsAg	☐ Positive ☐ Negative ☐ Not Tested	☐☐ Day ☐☐ Month ☐☐ Year Time : .....
Hepatitis C	Anti-HCV	☐ Positive ☐ Negative ☐ Not Tested	☐☐ Day ☐☐ Month ☐☐ Year Time : .....
Others		☐ Positive ☐ Negative ☐ Not Tested	☐☐ Day ☐☐ Month ☐☐ Year Time : .....

2.10 Results disclosed to source patient:

- Yes ☐
- No ☐

2.10.1 Date results disclosed: .....

☐☐ Day ☐☐ Month ☐☐ Year

(») to be filled in the registry

3. RISK ASSESSMENT OF THE EXPOSED HEALTH CARE WORKER (Please tick (✓) where applicable)

3.1 Marital status:

- Married ☐
- Single ☐
- Divorced ☐

3.2 Pregnancy status:

- Yes ☐
- No ☐
- Not Applicable ☐

3.3 Hepatitis B immunization status:

3.3.1 History of hepatitis B immunization before the exposure:

- No ☐
- One dose ☐
- Two doses ☐
- Three doses ☐

Level of antibody to hepatitis B (anti-HBs), if tested :

..... mIU/ml

Date of anti-HBs blood test : (as in 3.3.2): ☐☐ Day ☐☐ Month ☐☐ Year

»3.4 Baseline blood test:

Pathogen	Test	Result	Date & Time drawn
HIV	Anti-HIV	☐ Positive ☐ Negative ☐ Not Tested	☐☐ Day ☐☐ Month ☐☐ Year Time : .....
Hepatitis B	HBsAg	☐ Positive ☐ Negative ☐ Not Tested	☐☐ Day ☐☐ Month ☐☐ Year Time : .....
Hepatitis C	Anti-HCV	☐ Positive ☐ Negative ☐ Not Tested	☐☐ Day ☐☐ Month ☐☐ Year Time : .....
Others :		☐ Positive ☐ Negative ☐ Not Tested	☐☐ Day ☐☐ Month ☐☐ Year Time : .....

3.5 Is Post-exposure prophylaxis started?:

- Yes ☐
- No ☐

»3.6 Is follow-up required?

- Yes ☐
- No ☐

3.7 Assessment done by :

Name of Physician / Medical Officer : .....

Department : .....

Hospital : .....

Date : .....

(»») to be filled in the registry