BLOOD AND BODY FLUID (BBF) EXPOSURE FORM

YUKON COMMUNICABLE DISEASE CONTROL (YCDC)

FAX COMPLETED FORM TO YCDC AT 867-667-8349

Date form initiated: YYYY/MM/DD

A. EXPOSED PERSON (recipient of exposure) INFORMATION

Name	Date of birth YYYY/MM/DD	Age	Gender	☐ HCP ☐ Gen Public ☐ In-Patient
Address				
YHIS #	Home phone	Work phone	Cell phone	
Reporting person		Health care facility		

B. EXPOSURE INFORMATION

Date of exposure YYYY/MM/DD	Time of exposure	Place of exposure (city/town and location)

Body site of exposure: _____

Gloves worn: ☐ Yes ☐ No

Occupational exposure: ☐ Yes ☐ No If yes, describe: _____

Other personal protective equipment: ☐ Yes ☐ No If yes, describe: _____

Type of exposure:

- ☐ Percutaneous
  - If yes, describe: _____
  - (For example, needle gauge and type, dental instrument, sharp object)
- ☐ Permucosal
- ☐ Non-intact skin
  - If yes, is wound < 3 days old? ☐ Yes ☐ No
- ☐ Sexual assault

Blood visible (on object or in bodily fluid): ☐ Yes ☐ No

Bodily fluid exposed to:

- ☐ Blood
- ☐ Semen
- ☐ Vaginal secretions
- ☐ Pleural, amniotic, synovial or cerebrospinal fluids
- ☐ Saliva
- ☐ Transplanted tissues or organs
- ☐ Breast milk
- ☐ Other: _____

Description of exposure	Examination of exposed person

C. HISTORY OF IMMUNIZATION & SEROSTATUS OF *EXPOSED* PERSON

Immunization history

	Y	N	Unk	Date
Rec'd Hep B vaccination - dose 1	☐	☐	☐	YYYY/MM/DD
Rec'd Hep B vaccination - dose 2	☐	☐	☐	YYYY/MM/DD
Rec'd Hep B vaccination - dose 3	☐	☐	☐	YYYY/MM/DD

Serostatus history

	Y	N	Unk	Date of last test	Result
HBsAg	☐	☐	☐	YYYY/MM/DD	_____
Anti-HBc	☐	☐	☐	YYYY/MM/DD	_____
Anti-HBs	☐	☐	☐	YYYY/MM/DD	_____
Anti-HCV	☐	☐	☐	YYYY/MM/DD	_____
Anti-HIV 1&2	☐	☐	☐	YYYY/MM/DD	_____

D. INFORMATION ON *SOURCE* OF BLOOD AND/OR BODILY FLUID

Name	Date of birth YYYY/MM/DD	Age	Gender	YHIS #

Source risk factors: ☐ Known ☐ Unknown

If known, source in a high risk group for: ☐ HBV ☐ HCV ☐ HIV

(See Yukon BBF Exposure Management Guideline to determine risks)

Describe _____

_____

Status	Y	N	Unk	Date of last test
HBsAg +	☐	☐	☐	YYYY/MM/DD
Anti-HCV +	☐	☐	☐	YYYY/MM/DD
HCV RNA +	☐	☐	☐	YYYY/MM/DD
HIV +	☐	☐	☐	YYYY/MM/DD

E. BLOOD WORK TESTING OF EXPOSED & SOURCE PERSON

Mark *baseline* testing requisition "STAT." Indicate nature of STAT request on req. – Notify WGH Lab
For follow-up bloodwork recommendations refer to Yukon BBF Exposure Management Guideline.

EXPOSED recommended blood tests	Baseline:	_____ wk date:	_____ wk date:	_____ wk date:	_____ wk date:	_____ wk date:
	Due	Due	Due	Due	Due	Due
	Done	Done	Done	Done	Done	Done
	Baseline results	Results	Results	Results	Results	Results
HBsAg						
Anti-HBc						
Anti-HBs						
Anti-HCV						
Anti-HIV 1&2						

SOURCE blood tests	Date Drawn	Results
HBsAg		
Anti-HBc		
Anti-HBs		
Anti-HCV		
Anti-HIV 1&2		

	Lab results to be sent to:	Name
Source person	Source person's follow-up health care provider	
	YCDC	
Exposed person	Exposed person's follow-up health care provider	
	YCDC	

F. COUNSELLING

Exposed person has been counselled as outlined in Yukon BBF Exposure Management Guideline:

Risk of transmission based on exposure information to: ☐ HBV ☐ HCV ☐ HIV
Prevention of transmission of potential infections: ☐ HBV ☐ HCV ☐ HIV

G. RECOMMENDATIONS FOR MANAGEMENT OF EXPOSED PERSON

Consultation with:
☐ MOH ☐ YCDC ☐ Other
☐ BC Centre for Excellence in HIV/AIDS (BC-CfE)

Recommendations:

H. POST-EXPOSURE PROPHYLAXIS OF EXPOSED PERSON

	Date given
☐ Hep B vaccine (HBV) Dose#___	YYYY/MM/DD
☐ Hep B immune globulin (HBIg)	YYYY/MM/DD
☐ HIV post-exposure Prophylaxis (5 day starter kit)	YYYY/MM/DD

I. FOLLOW-UP PLAN

Designated follow-up health care provider:	Phone #	Fax #

Follow-up required by designated health care provider:

☐ Hepatitis B vaccine (HBV) - further doses of HBV to complete 3 dose series (refer to YCDC, Whitehorse Health Centre or nearest community health centre)

☐ HIV 5 day starter kit has been provided. Client must be assessed within 3 days. To determine the need for remainder of one month supply of antiretrovirals, consult with YCDC or the MOH

☐ Follow-up blood work as per section E:
- Baseline lab results will be sent to you
- Please follow-up with the client for results

Signature of reporting health care provider _____ Name (printed) _____ Date _____

Print Clear