NEEDLE STICK INJURY / SPLASH REPORTING FORM

Victim / Employee / Staff Information

Name : Bdsfbdfngn	Age / Sex : 42 / Female	D.O.B : 02-03-1992
Department : Sbsbsbsbs	Designation : Sbsbbsb	
Emp No : MGMFT4212	Mobile No. : 9845641515	Dept Extn : 2425
HEPATITIS B Vaccination Taken :	Yes	
If, yes, Year of Vaccination :	2nd Dose	
HBsAg / HCV / HIV / Status Known	adgagagagaga	
Part of body exposed	agagagagagagagaa	
Nature of Injury	OTHERS : rhehehrehrehhe	

Incident Details:

Any Previous Incident : eheheheeh	
Date of Incident : 09-03-2024	Time of Incident : 00:23
Incident Details : eheheheh	
Exposure by :	Patient used Needle
Which body fluid was involved	Blood or Blood products
Route of Exposure:	Non intact skin
Reported to Supervisor (Time):	Name of Supervisor : Ehehhh
Was protective equipment worn at the time of exposure?	Yes - jrtjrjrtjtrjrj
What device or Item caused the injury?	wgheherherh
How long was the blood or body fluid contact with the skin or mucus membrane?	5-14 min
Estimate the quantity of blood or body fluid that came in contact with the skin or mucus membrance:	Moderate Amount
Exposure:	Medium Risk

Patient / Donor Information:

Source of Patient : Known	Patient Name :eheheheh UHID No.: 900054565
Source of Patient : Known	Patient Name :eheheheh UHID No.: 900054565
Patient's Anti HCV status known?	Status :wggwrgwg Date of testing : 01-03-2024
Patient's HIV status known?	Status :wgwgwgw Date of testing : 01-03-2024
Test ordered for the source patient	wgwgwgwgwgw

Employee Details & Follow up Test

Investigation	Schedule	Date
HIV I@ II, p24 Ag	On the Day	08-03-2024
Anti HCV	On the Day	08-03-2024
LFT	On the Day	08-03-2024
HbsAg	On the Day	08-03-2024

Consent for Follow up Test

I _____ have accidentally got exposed to Blood / Body fluid of a patient by Prick / Splash during my duty hours, I understand that due to the nature of Exposure to blood or other potentially infectious materials I may be at risk of acquiring infections and I consent to take the follow up investigations as informed. I understand that, if I decline these investigations, I cannot hold the organization resposible for the consequences occuring in future.

Information Received by Date:

Onfectious Diseases Physician Signature, Reg. No :

ICN Signature, Emp No.:

Note:

If Retro Positive Case refer PEP - HIV Annexure Form. (Available at MGM Emergency Department)