



NEEDLE STICK INJURY / SPLASH REPORTING FORM

Victim / Employee / Staff Information

Name : LITTY THOMAS	Age / Sex : 34 / Female	D.O.B : 21-02-1990
Department : NURSING	Designation : ICN	
Emp No : MGMFT3867	Mobile No. : 9400520445	Dept Extn :
HEPATITIS B Vaccination Taken :	Yes	
If, yes, Year of Vaccination :	Booster Dose	
HBsAg / HCV / HIV / Status Known	NEGATIVE	
Part of body exposed	FINGER	
Nature of Injury	SHARP	

Incident Details:

Any Previous Incident : NO	
Date of Incident : 14-03-2024	Time of Incident : 09:02
Incident Details : WHILE RECAPPING	
Exposure by :	Patient used Needle
Which body fluid was involved	Blood or Blood products
Route of Exposure :	Needle stick
Reported to Supervisor (Time):	Name of Supervisor : Mr.CHANDRAVEL
Was protective equipment worn at the time of exposure?	Yes - GLOVES,MASK
What device or Item caused the injury?	NEEDLE
How long was the blood or body fluid contact with the skin or mucus membrane?	Less than 5 min
Estimate the quantity of blood or body fluid that came in contact with the skin or mucus membrane :	Small Amount
Exposure :	Low Risk

Patient / Donor Information:

Source of Patient : UnKnown	-
Patient's HBs Ag Status known?	No
Patient's Anti HCV status known?	No
Patient's HIV status known?	No
Test ordered for the source patient	

Employee Details & Follow up Test

Investigation	On the day of incident	1 1/2 Month	3rd Month	6th Month
---------------	------------------------	-------------	-----------	-----------

Treatment

HEPATITIS B Prophylaxis indicated :	Yes
HEPATITIS B Prophylaxis Given :	Immunoglobulin
Remarks : MBGDJKFNB ZHJHK	

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 responsible for the consequences occurring in future.

Information Received by

Date :

Infectious Diseases Physician Signature, Reg. No :

ICN Signature, Emp No.:

Note:

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