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wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

# Report on Needlestick Injury or Body Fluid Splash

Dear Employer:
Thank you for your recent Form 7 submission. We need more information to handle this claim. Your co-operation in providing the following information is kindly appreciated.

Worker Name:

Employer Name:

Accident Date: (dd-mmm-yyyy)

Claim No.:

## A. Exposure Information

Type of injury: (check all applicable)

Needlestick: ☐ Yes ☐ No

Splash: ☐ Yes ☐ No

Other: ☐ Yes ☐ No

Describe:

Site of Injury: (check all applicable)

☐ Finger ☐ Hand ☐ Arm

☐ Leg (lower) ☐ Leg (upper) ☐ Percutaneous

☐ Mucous Membrane ☐ Skin

Was the skin intact prior to puncture? ☐ Yes ☐ No

Source of injury: (check all applicable)

Infectious: ☐ Blood ☐ Fluid with visible blood

Potentially Infectious: ☐ Semen ☐ Vaginal Fluids ☐ Synovial Fluid ☐ Pericardial Fluid ☐ Cerebral Spinal Fluid

Volume of Fluid Injected: (check all applicable)

☐ Hollow device ☐ Solid sharp

☐ Injection needle ☐ Aspiration device

Sharp Device used in: (check all applicable)

☐ Artery ☐ Vein

☐ Subcutaneous tissue ☐ Intramuscular

## B. Source Material & Risk Transmission

Based on your investigation, please provide your best estimate of risk associated with this injury. (Check appropriate boxes).

Risk of HIV: ☐ Low ☐ Medium ☐ High

Risk of Hep B/C: ☐ Low ☐ Medium ☐ High

Source Material known to contain: ☐ Human Immune Virus (HIV) ☐ Hepatitis C Virus (HCV) ☐ Hepatitis B Virus (HBV) ☐ Unknown

## C. Medical Attention

Check all appropriate boxes and provide details if available:

☐ Employee Health Services — Please provide date: (dd-mmm-yyyy)

☐ Hospital Emergency — Please provide name and address: — Date: (dd-mmm-yyyy)

☐ Family Physician — Please provide name and address: — Date: (dd-mmm-yyyy)

Referral to Infectious Disease Specialist? ☐ Yes ☐ No — Please provide name and address: — Date: (dd-mmm-yyyy)

The worker received:

HIV PEP Medication: ☐ Yes ☐ No

HBV Vaccine: ☐ Yes ☐ No

Tetanus: ☐ Yes ☐ No

Date of Last Booster: (dd-mmm-yyyy)

Follow-up Appointment/Testing:

**When you contact the WSIB please indicate claim number**

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# Report on Needlestick Injury or Body Fluid Splash (cont.)

Claim No.

## D. Prevention

Was worker provided: (check all applicable)

Counselling: ☐ Yes ☐ No If yes, provided by:

A Preventative Measures discussion: ☐ Yes ☐ No If yes, provided by:

Follow-up support: ☐ Yes ☐ No If yes, provided by:

The worker's level of anxiety is: ☐ Low ☐ Medium ☐ High

## E. Lost Time

Has the worker lost time from work (since Form 7 was completed)? (dd-mmm-yyyy)

☐ Yes ☐ No If yes: From: _____ To: _____

**Please complete and return your response to the Occupational Disease & Survivor Benefits Program, WSIB by fax transmission within 72 hours.**

**Fax No: 416-344-2380 Toll Free Fax No.: 1-866-268-7797**

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