

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:	Claim No.:

A. Exposure Information

Type of injury: (check all applicable) Needlestick: <input type="checkbox"/> Yes <input type="checkbox"/> No Splash: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: <input type="checkbox"/> Yes <input type="checkbox"/> No	Site of Injury: (check all applicable) <input type="checkbox"/> Finger <input type="checkbox"/> Hand <input type="checkbox"/> Arm <input type="checkbox"/> Leg (lower) <input type="checkbox"/> Leg (upper) <input type="checkbox"/> Percutaneous <input type="checkbox"/> Mucous Membrane <input type="checkbox"/> Skin
Describe:	Was the skin intact prior to puncture? <input type="checkbox"/> Yes <input type="checkbox"/> No
Source of injury: (check all applicable) Infectious: <input type="checkbox"/> Blood Potentially Infectious: <input type="checkbox"/> Semen <input type="checkbox"/> Synovial Fluid <input type="checkbox"/> Cerebral Spinal Fluid <input type="checkbox"/> Fluid with visible blood <input type="checkbox"/> Vaginal Fluids <input type="checkbox"/> Pericardial Fluid	
Volume of Fluid Injected: (check all applicable) <input type="checkbox"/> Hollow device <input type="checkbox"/> Solid sharp <input type="checkbox"/> Injection needle <input type="checkbox"/> Aspiration device	Sharp Device used in: (check all applicable) <input type="checkbox"/> Artery <input type="checkbox"/> Vein <input type="checkbox"/> Subcutaneous tissue <input type="checkbox"/> 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: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	Risk of Hep B/C: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
Source Material known to contain: <input type="checkbox"/> Human Immune Virus (HIV) <input type="checkbox"/> Hepatitis C Virus (HCV) <input type="checkbox"/> Hepatitis B Virus (HBV) <input type="checkbox"/> Unknown	

C. Medical Attention

Check all appropriate boxes and provide details if available:

<input type="checkbox"/> Employee Health Services	Please provide date:
<input type="checkbox"/> Hospital Emergency	Please provide name and address:
	Date:
<input type="checkbox"/> Family Physician	Please provide name and address:
	Date:
Referral to Infectious Disease Specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please provide name and address:
	Date:

The worker received:

HIV PEP Medication: Yes No HBV Vaccine: Yes No Tetanus: Yes No

Date of Last Booster: _____

Follow-up Appointment/Testing: _____

When you contact the WSIB please indicate claim number

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)?

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