SHARPS INJURY SURVEILLANCE
OCCUPATIONAL HEALTH UNIT
MINISTRY OF HEALTH

"Rakan Anda Dalam Meningkatkan Kesihatan Pekerja"
"Your Partner In Enhancing Workers Health"

OCCUPATIONAL INTERVENTION FORM FOR INFECTED HEALTH CARE WORKERS FOLLOWING SHARPS INJURY OHU/SIS-3

Occupational Intervention Form For Infected Health Care Workers Following Sharps Injury

(Please tick (✓) where applicable)

(To be filled up by Hospital Director or District Medical Officer of Health. This form needs to be sent to Occupational Health Unit / Infection Control Unit in the hospital or District Occupational Health Unit / Safety and Health Committee Secretary).

PARTICULARS OF INFECTED HEALTH CARE WORKERS

1. Name of Health Care Worker (HCW)
2. NRIC : New : ☐☐☐☐☐☐ – ☐☐ – ☐☐☐☐
   Old : ☐☐☐☐☐☐☐☐

3. R/N :

INFORMATION

»1. Date of notification of the status of infection to Hospital Director or district Medical Officer of Health	☐☐ Day ☐☐ Month ☐☐ Year
»2. Type of infection	☐ HIV ☐ Hepatitis B ☐ Hepatitis C
»3. Particulars of the treating physician	Name : ..... Department : ..... Hospital : .....
»4. Date of assessment of HCW's work task	☐☐ Day ☐☐ Month ☐☐ Year
»5. Is the HCW's work task involving Exposure Prone Procedure (EPP)?	☐ Yes ☐ No ..... (End here)

(») to be filled in the registry

»6. Does the serological result allow HCW's to continue EPP?	☐ Yes : For Hepatitis B-Periodical Monitoring (Refer to appendix: periodical monitoring for Hepatitis B) ☐ No
»7. Is local arrangement for work modification done?	☐ Yes ☐ No……..Continue to no. 9 ☐ Not indicated
8. Work modification done	☐ Yes - date: ☐☐ Day ☐☐ Month ☐☐ Year - Specify the modification……
»9. Date of referral to Advisory Panel	☐☐ Day ☐☐ Month ☐☐ Year
»10. Date of decision made by Advisory Panel	☐☐ Day ☐☐ Month ☐☐ Year
»11. Decision made on work modification during the Advisory Panel meeting	☐ Need work modification ☐ Do not need work modification ☐ Others, specify……
12. Has the work modification advised by the Advisory Panel been done?	☐ Yes ; specify …… ☐ No
»13. Date of starting modification of work	☐☐ Day ☐☐ Month ☐☐ Year (End here)
»14. Has the HCW requested for referral to Appellate Medical Board (3 months after the date of decision by Advisory Panel)?	☐ Yes ; specify the date ☐ No …… (End here)
»15. Decision made on work modification during the Appellate Medical Board	☐ Need work modification ☐ Do not need work modification ☐ Others, specify……
»16. Has the work modification advised by the Appellate Medical Board been done?	☐ Yes ; specify …… ☐ No

Comments or suggestions:

_____

_____

Name of Hospital Director / District Medical Officer of Health : _____

Name of Hospital / District Health Office : _____ Date: _____

Official stamp : _____

(»») to be filled in the registry

Appendix:

Periodical monitoring For Hepatitis B

Date of blood test done	Blood test result		Serological result fulfilled the criteria to continue with EPP (Yes/No)	Job modification done			
	HBe Ag (Positive/ Negative)	($<10^4$ copies/ml/ $\geq 10^4$ copies/ ml)		Yes		No (/)	Not indicated (/)
				Date of commencement	Action taken (Specify)		

Note :

1) Periodical monitoring to be done 3 monthly

2) Once job modification indicated but not done, refer to Advisory panel and re-complete the occupational intervention form (starting from no. 9)