Report on needlestick injury or body fluid splash

Claim number

Visit wsib.ca/submit to submit this form and supporting documents.

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)

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	Synovial fluid	Cerebral spinal fluid
	Vaginal fluids	Pericardial 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 and 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 Date (dd/mmm/yyyy)	Please provide name and address
Family Physician Date (dd/mmm/yyyy)	Please provide name and address
Referral to Infectious Disease Specialist? Yes No Date (dd/mmm/yyyy)	Please provide name and address

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

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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 (dd/mmm/yyyy) ______ To (dd/mmm/yyyy) ______