



**SHARPS INJURY SURVEILLANCE  
OCCUPATIONAL HEALTH UNIT  
MINISTRY OF HEALTH**

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



OHU/SIS-2b

# MANAGEMENT OF THE EXPOSED HEALTH CARE WORKER SECTION (OHU/SIS-2b)

**OHU/SIS-2b : Post-Exposure Management (Treatment and follow-up of the exposed healthcare worker)**

(to be filled by staff from Infection Control Team / Occupational Health Unit / Occupational Safety and Health Committee Secretary)

**1. Management of the Exposed Health Care Worker:**

(Please tick (✓) where applicable)

**»1.1 Post exposure Prophylaxis (PEP) given:**

- Yes
- No

PEP	Requirement	Data given	Data Completion	Duration/ Medication/ Comments
HBIG	<input type="checkbox"/> 1 dose	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
	<input type="checkbox"/> 2 doses	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
HIV PEP	<input type="checkbox"/> Basic regime	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
	<input type="checkbox"/> Expanded regime	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
Others :		<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	

(») to be filled in the registry

»1.2 **Hepatitis B Immunization Needed:** (Please tick (✓) where applicable)

• Yes

• No

Immunization	Dose	Date given	Medication/Duration/Comments
Hepatitis B (Immunization)	<input type="checkbox"/> First dose	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
	<input type="checkbox"/> Second dose	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	
	<input type="checkbox"/> Third dose	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year	

Test	Result	Date given
Anti-HBs (1-2 months after completion Hepatitis B immunization)	..... mIU/ml	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year

»1.3 **Follow-up blood test:** (Please tick (✓) where applicable)

Pathogen	Test	Result	Date drawn
<b>HIV</b>	Anti-HIV (At 6 weeks post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
	Anti-HIV (At 3 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
	Anti-HIV (At 6 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
<b>Hepatitis B</b>	HBsAg (At 6 weeks post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
	HBsAg (At 3 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
	HBsAg (At 6 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
<b>Hepatitis C</b>	Anti-HCV (At 6 weeks post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
	HCV RNA (At 6 weeks post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
	Anti-HCV (At 3 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
	Anti-HCV (At 6 months post incident)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year
<b>Others:</b>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	<input type="text"/> <input type="text"/> <input type="text"/> Day Month Year

**1.4 Comments and subsequent actions based on the results:** (Please tick (✓) where applicable)

**1.4.1 Seroconversion status:**

- Yes
- No

**1.4.2 If yes, referral to:**

- Physician from relevant discipline for further clinical management
  
- Hospital Director / District Medical Officer of Health for assessment of work task involving 'exposure prone procedure' (EPP)

Name of Physician : .....

Department : .....

Hospital : .....

Hospital Director / District Medical

.....

.....

Date of appointment : .....

Name of attending Medical Officer : .....

Department : .....

Hospital : .....

Date : .....