Needle Stick Injury Form

Name of Hospital:

District: **Date:**

NEEDLE STICK INJURY FORM

Sr. No.	Parameters		Remarks
1.	Name of Health Care Worker (HCW)		
2.	Name of the Unit & Department		
3.	Date and Time of Needle Stick/Sharp Injury		
4.	Date and Time of Reporting to ICN		
5.	Site of Injury		
6.	Nature of Injury	Needle Prick /Sharp Cut/Lacerations/Splash of Fluids / Splattered Glass/Others (Please specify)	
7.	Source of Injury (If Available)		
8.	Risk Category		
9.	Action taken on site		
10.	Pre-exposure Prophylaxis given	Yes/No	
11.	Date Time & Type of Vaccination		
12.	Whether vaccination taken after exposure	Yes/No	
13.	If taken after exposure Date Time and Type of Vaccination		
14.	If not taken after exposure reasons for the same		

15.	**Test Results after exposure with method used.**		

Filled By:_____ Submitted to:_____

Action Taken: _____

Disclaimer

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