

QUESTIONNAIRE 1: Exposure of Healthcare Workers

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Family name: \_\_\_\_\_ First name: \_\_\_\_\_

Position: \_\_\_\_\_ Department: \_\_\_\_\_

Day at work:    ☐ 14/05/08        ☐ 19/05/08        ☐ 20/05/08        ☐ other:

Working hours:        ☐ 7–14 h        ☐ 14–21 h        ☐ 21–7 h

### *Search for potential exposure:*

|                                              |                                                                                                                                                       |                             |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Contact <1 m:                                | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Patient interviewed:                         | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Buccal examination:                          | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Orotracheal intubation:                      | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Tracheal aspiration:                         | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Aerosol therapy:                             | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Respiratory physiotherapy:                   | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Bronchial endoscopy:                         | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Projection of biological fluids:             | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Lumbar puncture:                             | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Nursing care:                                | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Treatments of the mouth:                     | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Contact patient with fluid(s) and/or mucosa: | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Bitten by the patient:                       | <input type="checkbox"/> Yes                                                                                                                          | <input type="checkbox"/> No |
| Contact:                                     | <input type="checkbox"/> No <input type="checkbox"/> blood <input type="checkbox"/> urine <input type="checkbox"/> feces <input type="checkbox"/> CSF |                             |
|                                              | <input type="checkbox"/> Handled biological specimens in the laboratory                                                                               |                             |

### *Application of standard precautions:*

Wearing of:        ☐ No        ☐ gloves        ☐ surgical mask  
                         ☐ lab coat or apron        ☐ glasses  
                         ☐ Handled tubes containing biological specimens under the hood

### *Exposure to rabies risk:*

Probable exposure:        ☐ Yes        ☐ No

### *Medical management by the Center for Treatment Anti-Rabies of the Institut Pasteur de la Guyane:*

Person to be seen again:        ☐ Yes        ☐ No