First Aid following BBFE

In the event of a potential exposure, the following first aid measures should be taken:

- Cleanse body sites exposed to potentially infectious blood/body fluids immediately with soap and water.
- Avoid the use of alcohol, hydrogen peroxide, bleach or other chemical cleansers/antiseptics/disinfectants.
- Do not “milk” the wound as squeezing may promote hyperemia and inflammation at the wound site, potentially increasing exposure if HIV is present.
- Allow injury/wound to bleed freely, then cover lightly.
- Flush exposed mucous membranes (including eyes) with water or normal saline.
Injury Report Instructions

The numbers refer to question numbers on the form that may require additional explanation.

Worker Details

1. Have your work duties been modified?
   Your duties have been modified if your employer made changes to regular job duties, as a result of an injury. For example, tasks or functions, workload (e.g., hours or work schedules), environment or work area, equipment.
   Please indicate if you are working as an apprentice.

Employer Details

2. Please complete all the information.

Accident Details

3. Date and time of accident
   If your injury developed over a period of time, indicate either the date of first medical treatment or the date you first reported it to your employer and check the box at the right. On the next line, give your start and end times on the day of the accident.

4. Date accident/injury reported to employer
   Please provide an accurate date and time someone from your work was made aware of your injury. Name the person, their position and their contact information.
   If you could not report your injury immediately, please provide a reason.

5. Describe fully what happened to cause the injury
   In your own words, tell us about your injury. If a repetitive strain injury, include your typical actions and how often you repeat them on the job – twisting, typing, pushing and pulling. If any lifting, indicate the weight.
   Example: I walked into our walk-in cooler to get a 50 lb. sack of potatoes. I bent down, picked up the sack, and turned to my right to leave. I felt a pull in my lower back and dropped the potatoes on my right foot. As a result, I injured my back and my right foot.
   Should you need more space than the area provided, please attach a letter.

Call the Claims Contact Centre 780-498-3999 or 1-866-922-9221 if you are reporting one of the following:

1. Repetitive strain injury
   For example, a typist developed tendonitis in the wrist as a result of job duties. Describe fully the job duties done each day. Include the time spent at each task.

2. Occupational disease
   Describe hearing loss, respiratory problems, etc. due to prolonged exposure to gas, chemicals, loud noises, etc.

3. Motor vehicle accident
   Send us a copy of the police report, when available. Fill out the Automobile Accident Report in this booklet.

6. Location of accident
   Wherever the accident occurred, please provide a street address, if possible. Otherwise, indicate the location, such as 25 km east of Edmonton on Hwy 16, an oilrig site. If it is a motor vehicle accident, include the direction of travel.

Injury Details

Indicate the part of your body that was injured, what side of your body and what type of injury it is. When your doctor or chiropractor sends in your medical report we will confirm your injury.
Injury Details

What part of body was injured? (hand, eye, back, lungs, etc.)

- Left side
- Right side

What type of injury is this? (sprain, strain, bruise, etc.)

Worker Details

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Initial:</th>
</tr>
</thead>
</table>

Mailing Address: Apt# , City: Province: Postal Code:

Phone Number: Social Insurance #: Personal Health #: Date of Birth: (Year / Month / Day) Gender: M F

Employer Details

| Employer Business Name: |

Mailing Address: City: Province: Postal Code:

Contact Name: Title: Phone: E-mail:

Accident Details

Date/time of accident: (Year / Month / Day) Time: a.m. p.m. or the injury/condition developed over time

Date/time shift started (if applicable): (Year / Month / Day) Time: a.m. p.m.

Date/time shift ended (if applicable): (Year / Month / Day) Time: a.m. p.m.

Name of person and their position: Phone Number:

If not reported immediately, give the reason:

Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what you were doing, including details about any tools, equipment, materials, etc. you were using. State any gas, chemicals or extreme temperatures you may have been exposed to:

Motor vehicle accident? Cardiac condition/injury? Claimed to another WCB? Province:

If you have more information or a list of witnesses, please attach a letter. Please check this box if letter is attached.

Have you had a similar injury before? Yes No If yes, attach a letter with details.

Was the work you were doing for the purpose of your employer’s business? Yes No Was it part of your usual work? Yes No

Did the accident/injury occur on employer’s premises? Yes No

Location where the accident happened (address, general location or site):

Full name of treating hospital or healthcare professional:

Address: Phone:

Injury Details

What part of body was injured? (hand, eye, back, lungs, etc.)

- Left side
- Right side

What type of injury is this? (sprain, strain, bruise, etc.)

Complete all three pages and sign the form before sending.

If your injury is the result of a motor vehicle accident, complete the Motor Vehicle Accident Report (L-054).
7 **Return-to-Work Details**
Please complete all the information that applies.

**Employment Details**
8 Complete one of the following A or B or C.
- Complete A if you work 12 months per year with the same employer.
- Complete B if you work only part of the year (subject to seasonal or lack of work layoffs).
- Complete C if you are self-employed, are a subcontractor or do piecework.

**Earnings Details**
9 b) Additional taxable benefits:
- **Vacation and statutory holiday pay**
  Please indicate if you are paid holiday and stat pay as an additional percentage on your paycheque or, if these days are included as days off with pay.
- **Shift premiums**
  Complete if you receive pay in addition to your regular rate of pay (e.g., 50¢ paid per hour for night shift). Provide your gross shift premium earnings for one year prior to the date of injury (less if you have not worked a full year).

**Overtime**
Complete only if you work the same number of hours overtime each week, month or shift cycle.

**c) Second job**
Provide a contact name and telephone number for a second job. If this injury causes you to miss earnings from that job, WCB-Alberta will consider these earnings when your compensation rate is set. Your second employer may be contacted.

*If you do not know your hours of work and wage information, you can get them from your employer.*

**Hours of Work Details**
10 a) **Number of hours**
Indicate your regular hours of work. Do not include overtime here.
<table>
<thead>
<tr>
<th>Worker's Last Name:</th>
<th>Worker's First Name:</th>
<th>Initial:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Insurance #:</td>
<td>Date of Birth:</td>
<td></td>
</tr>
</tbody>
</table>

**Return to Work Details**  
*Please complete all that apply*

7. a. Will/did your employer pay you while off work?  
   [ ] No  [ ] Yes, pre-accident wages  [ ] Unknown

7. b. Date and time you first missed work:  
   (Year / Month / Day)  
   Time: _____ : _____  
   [ ] a.m.  [ ] p.m.

7. c. If you have returned to work indicate date:  
   (Year / Month / Day)  
   Time: _____ : _____  
   [ ] a.m.  [ ] p.m.

   Current work status:  
   [ ] Regular work duties, or  
   [ ] Modified work duties  
   [ ] Regular hours of work, or  
   [ ] Modified hours of work: _____ hrs per _______

   [ ] Pre-accident rate of pay, or  
   [ ] Revised rate of pay: $ _____________ per _________

   If you are working modified duties please describe:

**Employment Type Details**  
*(Complete A or B or C. Select your type of employment.)*

3. A. Permanent position employed 12 months of the year:
   - [ ] Permanent full-time  
   - [ ] Permanent part-time  
   - [ ] Irregular/casual

3. B. Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):
   - [ ] Seasonal worker  
   - [ ] Summer student  
   - [ ] Temporary position

   Had this injury not occurred, your last day of employment would have been:
   
   Position start: (Year / Month / Day)  
   Position end: (Year / Month / Day)  
   [ ] Estimated, or  [ ] Actual

   How many months or days are workers employed in this position? ______________

3. C. Special employment circumstance:
   - [ ] Sub contractor  
   - [ ] Vehicle owner/operator  
   - [ ] Welder owner/operator  
   - [ ] Commission  
   - [ ] Piece work  
   - [ ] Volunteer  
   - [ ] Self-employed

   Do you incur expenses to perform the work (materials, tools, etc.)?  
   [ ] Yes  [ ] No  
   Will you receive a T4?  
   [ ] Yes  [ ] No

   Note: If you have checked any box in 8C please submit a detailed income and expense statement.

**Earning Details**

a. Your rate of pay at time of accident: $ _____________ per  
   [ ] Hour  [ ] Day  [ ] Week  [ ] Month  [ ] Year

9. b. Additional taxable benefits:
   - [ ] Vacation Pay: ______________
   - [ ] Taken as time off with pay  
   - [ ] Paid on a regular basis %

   [ ] Shift Premium  
   Please describe:
   [ ] Overtime  
   [ ] Other

   c. Do you have a second job?  
   (Second employer may be contacted)  
   [ ] Yes  [ ] No  
   [ ] If yes  
   Employer’s Name:  
   Phone:

   d. Did you miss time from this second job?  
   [ ] Yes  [ ] No  
   If yes, please attach earning information and time missed details.

**Hours of Work Details**

a. Number of hours (not including overtime): _________ per week

   Describe your work schedule (e.g., Monday to Friday, on. Saturday to Sunday, off.):

   ____________________________________________________________

   ____________________________________________________________
I declare that the information in the Worker Report of Injury or Occupational Disease form will be true and correct.

I understand that:

• While I am receiving any benefits from WCB-Alberta, it is my obligation to inform WCB-Alberta immediately if I return to work of any kind, become capable of working or if there is any other change in my employment status. Work includes but is not limited to any activity in which labour or services are provided, whether or not payment of any kind is received.

• Criminal prosecution may result from any attempt on my part to collect benefits by providing false information, failing to provide information regarding my ability to work, or other fraudulent means.

• My employer may request a review or appeal of any decisions made on my claim and may therefore examine my claim file. My claim file may also be examined by anyone with a direct interest, as determined by WCB-Alberta, or a person or company I have authorized to review my claim file. (To provide authorization, use the Worker's Information Release form in the Worker Handbook).

• My social insurance number may be used for reporting to Canada Revenue Agency.

• WCB-Alberta may collect information that it considers relevant to determine benefits, including information pre-dating my accident, from any source including physicians, other health care providers, employer(s) and vocational rehabilitation service providers. This information is collected to determine my entitlement to compensation under the Workers' Compensation Act.

WCB-Alberta may use and disclose the information collected to determine entitlement, to provide services and benefits, and, as required or authorized by law. This information may be used and disclosed pursuant to the Workers’ Compensation Act and the Freedom of Information and Protection of Privacy Act.

Date: __________________________  Name (please print): ________________________________

Signature: ____________________________________________

Signing the above consent enables the Workers’ Compensation Board to process your claim.

NOTE: The information required in the Worker Report of Injury or Occupational Disease is collected under sections 33(a) and (c) of the Freedom of Information and Protection of Privacy Act for the purpose of determining entitlement to compensation and for determining employers’ premium rates. Questions may be directed to the Claims Contact Centre as noted on the front of this form and on the back of the Worker Handbook. The information provided to the Workers’ Compensation Board is protected by the provisions of the Freedom of Information and Protection of Privacy Act.

This report form is part of a booklet of information intended to help workers with completing the necessary WCB-Alberta forms and understanding the process. Keep the booklet for your reference.
Responsibility for Payment

The Alberta OHS Act, Regulation and Code address the responsibilities of employers and workers in ensuring a safe workplace. Part 35 of the OHS Code addresses the control of worker exposures to blood and bodily fluids and other biohazardous materials, procedures for working with medical sharps, and post-exposure follow up (http://work.alberta.ca/documents/WHS-LEG_ohsc_p35.pdf).

In addition the Alberta Government PEP Guidelines state:

*In case of an exposure, the employer is responsible to make sure that first aid and medical attention are made available to the affected worker(s), and that workers are made aware of the requirement to report and seek attention for such exposures. An employer is responsible to provide and pay for these services (through insurance in most cases) as they are not provided through the publicly funded health system.*

Health Professionals with Expertise in Blood and Body Fluid Exposures

It is critical to contact a health professional with expertise in blood and body fluid exposures as soon as possible after an exposure, preferably within 1-2 hours. Treatment may not be available if it cannot be started within 72 hours of exposure.

The following may be contacted to provide advice and follow-up. There may be specific health professionals designated in your location who will provide follow up.

- HealthLink
- Local Emergency Department
- Public Health/Medical Officers of Health
- Family Physicians
Only a Health Professional knowledgeable in BBFE should be completing the assessment to determine if the exposure is high risk. The **Occupational Blood/Body Fluid Exposure Follow-Up** form provided here may help you to gather relevant information prior to seeing your Health Professional, but don't worry if the terms are unfamiliar or if you are not sure of the response. Seek their advice. *The following questions may be asked by the health professional responsible for conducting the risk assessment.*

**Type of substance to which worker was exposed:**
- Is the substance fresh blood?
- Is the substance a high risk body fluid, such as semen?
- Is the exposure to dried, old blood?
- Is the exposure to low-risk secretions (tears, saliva, urine)?

**Type of transmission:**
- Is the transmission intravenous?
- Is the transmission intramuscular?
- Is the transmission deep transcutaneous with visible bleeding at the site?
- Is the transmission through superficial transcutaneous with no visible bleeding?
- Is the transmission through mucosal contact only?
- Is the exposure to intact skin?

**Source risk:**
- Is the source known to be HIV, HBV, or HCV infected?
  - If yes, does the carrier have acute AIDS illness, hospitalized and/or known high viral load for HIV, HBV, or HCV?
  - If yes, is the carrier asymptomatic?
- Is the source HIV, HBV, HCV status unknown?
  - If yes, is the source potentially high risk (suspected HIV+, HVB+ or HCV+; injection drug user; unknown needle in an area of high HIV prevalence)?

**Quantity of inoculum/exposure:**
- Is it massive, such as in a transfusion?
- Is it more than 1 ml?
- Was the needle large-bore and hollow – larger than 22 gauge?
- Was the needle small-bore and hollow – smaller than 22 gauge?
- Was the inoculum trace, on the surface only?

*The health professional considers these factors in addition to information about the assessment of the injury, as well as ordering testing on the source patient (if available) and a physical exam, history taking and baseline testing on the exposed worker.*
**Occupational Blood/Body Fluid Exposure Follow-Up**

<table>
<thead>
<tr>
<th>Employee exposed:</th>
<th>Date of report:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of exposure:</td>
<td>Time of exposure:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee name:</th>
<th>Employee address:</th>
<th>Alberta Health Card number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male ☐ Female</td>
<td>Employee phone number:</td>
<td>Alternate phone number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee’s Family Physician:</th>
<th>Physician’s contact information:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employee Occupation:</th>
<th>Task during which exposure occurred:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer:</th>
<th>Employer address:</th>
<th>Employer phone number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does the employer have a WCB account? ☐ Yes ☐ No</th>
<th>If yes, WCB account number:</th>
<th>If no, employer’s billing address:</th>
</tr>
</thead>
</table>

### Exposure Incident Details

- ☐ Needle stick/sharps incident
  - ☐ Large bore needle ☐ Solid bore needle ☐ other sharp (specify)
  - ☐ Deep puncture wound ☐ Moderate with skin penetration and blood ☐ Superficial scratch, no visible blood
  - Needle/sharp with visible blood contamination? ☐ Yes ☐ No

- ☐ Human bite resulting in skin broken

- ☐ Body fluid exposure
  - ☐ Contact with mucous membrane
  - ☐ Contact with non-intact skin

<table>
<thead>
<tr>
<th>Type of body fluid</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Area of body exposed:</th>
</tr>
</thead>
</table>

### Source Information

- ☐ Known ☐ Unknown | If known, name: | DOB: |

<table>
<thead>
<tr>
<th>Source Alberta Health Number:</th>
</tr>
</thead>
</table>
HIV PEP Starter Kits

If the exposure is determined to be high risk based on the source patient or mechanism of exposure, a Post HIV Exposure Prophylactic (HIV PEP) starter kit is made available with the first 7-days of medication (of the recommended 28 day course of prophylaxis). PEP starter kits must be started as soon as possible after exposure, and are not provided if the exposure occurred more than 72 hours ago.

The kit to be used will contain either two or three drugs, depending upon risk assessments. Kits are only to be released after approval by the responsible physician to ensure standardized risk assessment and appropriate follow-up.
Post BBFE Counselling

Following a BBFE, counselling is provided to the exposed worker by a Medical Officer of Health, an Infectious Disease specialist, a Communicable Disease Nurse, or an Occupational Health Nurse. In some cases, family physicians or Emergency Room physicians may provide counselling. Counselling should address (but is not limited to) the following topics:

- A review of risk of transmission of HIV, HBV and HCV following a BBFE
- Support available to help deal with anxiety related to the BBFE
- Explanation of the meaning of test results for HIV, HBV, HCV
- Potential side effects and contraindications for PEP
- Description of follow-up testing
- Advising the exposed person to not donate blood, tissues, organs or semen until infection has been ruled out
- The need to practice safer sex (i.e. use condoms) or abstain from sexual intercourse until infection has been ruled out (usually until a follow up blood serology is performed 12 weeks after the exposure)
- Advising the exposed person to abstain from any practices that can lead to HIV, HBV or HCV transmission (such as sharing needles for intravenous drug use)
- An overview of symptoms that may suggest seroconversion and follow-up contacts
High Risk Source

A source with any of the following conditions is considered a high risk source.

- Hepatitis B +
- Hepatitis C +
- HIV +
- Intravenous drug user
- History of incarceration
- Shared needles or drug paraphernalia for drug use in preceding 6 months
- Multiple sex partners or sex with sex-trade workers in the last 6 months
- Presence of symptoms of HIV infection (for more details, link to https://myhealth.alberta.ca/Health/pages/conditions.aspx?hwid=hw151408)

Health professionals conducting the risk assessment will take this into consideration, along with other significant factors, when determining whether any treatment of the exposed worker is required.
In the event of a blood and body fluid exposure, the source (if known) of the blood or body fluid will be informed of the exposure and asked for permission to test for Hepatitis B, Hepatitis C and HIV.

In most cases, this request will not be made by the person who was exposed to the blood or body fluid, but rather by another appropriately trained health professional. The person informing the patient should let them know that the MOH or an ID specialist will contact them to follow up. In the event that no one else can have this conversation or obtain consent, the exposed worker may approach the patient for consent but needs to consider the ethics of the situation and be alert to avoid pressuring or coercing the patient into testing, which is voluntary. In all cases, the patient should be informed that test results will be shared with the source patient and their doctor for follow up.

The following page provides an example of a form used to obtain consent to test a source patient. Any consent should be documented.
SOURCE AUTHORIZATION FOR TESTING

FOLLOWING an EXPOSURE TO BLOOD and/or BODY FLUIDS

While caring for you (or your family member) a Health Care Worker or Client was accidentally exposed to your blood &/or body fluid.

Following an exposure, health care workers are concerned about their health and safety because of the risk of contracting HIV, Hepatitis B or Hepatitis C should you be infected.

People infected with these viruses may not look or feel sick. The best way to know if you carry a virus, which could be transmitted to another person, is through a blood test.

We ask your permission to test you for Hepatitis B, Hepatitis C and HIV.

Testing is voluntary, which means you may refuse without jeopardizing your care in any way. Your physician will review the results of the test with you.

Test results will be disclosed to the exposed health care worker to determine the appropriate post-exposure management protocol.

I, the undersigned, consent to the following tests;

✔ Hepatitis B Surface Antigen
✔ Hepatitis C Antibody
✔ HIV Antibody

I understand;

the circumstances related to the exposure.
the reasons why the test is considered necessary.
the nature of the diseases and how they are transmitted.

______________________________  ______________________________
Signature of Source Patient/Client  Signature of Witness

______________________________  ______________________________
Print Source Patient/Client Name  Print Witness Name

______________________________  ______________________________
Date  Date
Testing following BBFE

Both the recipient (worker) of the BBFE and the source patient have their blood tested. A qualified health care provider requests the tests.

The tests are conducted at the Provincial Laboratory. The tests are ordered as URGENT to obtain the results as quickly as possible. In some situations and locations, a Rapid HIV test is available for the source patient’s blood, with results provided within 1-2 hours.
Recommended HIV Post Exposure Prophylaxis*

*These currently prescribed guidelines have been reproduced from the Alberta Guidelines for Non-Occupational, Occupational and Mandatory Testing and Disclosure Act Post-Exposure Management and Prophylaxis: HIV, Hepatitis B, Hepatitis C and Sexually Transmitted Infections (PEP Guidelines); Alberta Government, February 2015. They are provided for your reference, however it is important to note that medications regimens are continually updated. Refer to http://www.health.alberta.ca/documents/PEP-Guidelines-2015.pdf for the most up to date recommendations.

Table 2: ADULT Regimens for 28-day Post-exposure Prophylaxis for HIV Infection

<table>
<thead>
<tr>
<th>Two-drug regimens</th>
<th>Three-drug regimens§</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prefered</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Tenofovir – emtricitabine‡ (Truvada®) | tenofovir – emtricitabine‡ (Truvada®)
| Plus | Plus |
| Dolutegravir (Tivicay®) or raltegravir (Isentress®) | dolutegravir (Tivicay®) or raltegravir (Isentress®) |
| **Alternate**     |                      |
| Zidovudine – lamivudine§ (Combivir®) | tenofovir – emtricitabine‡ or zidovudine – lamivudine§ (Combivir®)
| Plus | Plus |
| Darunavir – ritonavir¶ (Prezista®-Norvir®) | darunavir – ritonavir¶ (Prezista®-Norvir®) |

‡ As a fixed dose combination product (Truvada®). Tenofovir-emtricitabine should not be administered with lamivudine-containing products (Gilead Sciences Canada, Inc. Pr- Truvada®, PM, 2009). The dose of tenofovir-emtricitabine should be reduced to one tablet every 48 hours in patients with a creatinine clearance of 30 to 49 ml per minute. Tenofovir-emtricitabine is not recommended in patients with a creatinine clearance of less than 30 ml per minute or in patients who are undergoing hemodialysis. Expert consultation should be sought in these cases.

§ Zidovudine–lamivudine is not recommended in patients with a creatinine clearance of less than 50 ml per minute.

¶ The boosting agent ritonavir is not considered to be an active drug in tabulating the number of agents in the three-drug regimen.
Recommended HBV Post Exposure Prophylaxis*

*These currently prescribed guidelines have been reproduced from the *Alberta Guidelines for Non-Occupational, Occupational and Mandatory Testing and Disclosure Act Post-Exposure Management and Prophylaxis: HIV, Hepatitis B, Hepatitis C and Sexually Transmitted Infections (PEP Guidelines)*; Alberta Government, February 2015.

Table 14: HBV post-exposure prophylaxis for non-sexual exposures

<table>
<thead>
<tr>
<th>RECIPIENT</th>
<th>SOURCE</th>
<th>SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imunimmunized</td>
<td>HBIG$ and initiate vaccine series‡ anti-HBs 1-6 months after series complete and at least 6 months after HBIG$</td>
<td>Initiato vaccine series‡ anti-HBs 1-6 months after series complete</td>
</tr>
<tr>
<td>Preiously immunized with complete series</td>
<td>Responder**</td>
<td>No treatment</td>
</tr>
<tr>
<td>Response &lt;10 IU/L and testing &gt;6 months after last dose</td>
<td>HBIG$ and 1 dose of vaccine anti-HBs 6 months after if still &lt;10 IU/L complete the second series then anti-HBs 1 month after</td>
<td>One dose of vaccine anti-HBs 1 month after if still &lt;10 IU/L complete the second series then anti-HBs 1 month after</td>
</tr>
<tr>
<td>Response &lt;10 IU/L and testing 1-6 months after last dose</td>
<td>HBIG$ and complete second course of vaccine series‡ anti-HBs 1-6 months after series complete and at least 6 months after HBIG$</td>
<td>Complete second course of vaccine series‡ anti-HBs 1-6 months after series complete</td>
</tr>
<tr>
<td>Non-responder† after 2 series of 3 does of vaccine</td>
<td>HBIG$ x 2 administered 1 month apart</td>
<td>No treatment</td>
</tr>
<tr>
<td>Previously immunized with incomplete series</td>
<td>Received 1 dose of vaccine</td>
<td>HBIG$ and complete vaccine series‡ anti-HBs 1-6 months after series complete and at least 6 months after HBIG$</td>
</tr>
<tr>
<td>Received 2 doses of vaccine</td>
<td>Give 3rd dose of vaccine If baseline anti-HBs is adequate, no further treatment is required If baseline anti-HBs inadequate† administer HBIG$ Test anti-HBs 6 months after HBIG$, if inadequate, complete second course of vaccine series</td>
<td>Give 3rd dose of vaccine anti-HBs 1-6 months after series complete</td>
</tr>
</tbody>
</table>
Recommended HCV Post Exposure Prophylaxis*

*These currently prescribed guidelines have been reproduced from the Alberta Guidelines for Non-Occupational, Occupational and Mandatory Testing and Disclosure Act Post-Exposure Management and Prophylaxis: HIV, Hepatitis B, Hepatitis C and Sexually Transmitted Infections (PEP Guidelines); Alberta Government, February 2015

HCV Post-exposure Prophylaxis

Currently, prophylaxis of HCV is neither available nor recommended although early identification of infection following exposure should be accompanied by referral to an infectious disease or gastroenterology/hepatology specialist for further assessment. This referral should be carried out on a semi-urgent basis with assessment occurring within 1 to 3 months of new diagnosis.