

**SHARPS / CONTAMINATION INCIDENT**

**SOURCE QUESTIONNAIRE**

The member of staff / student involved with your treatment has suffered a sharps / contamination incident. It is important to know if this will put them at risk. In order to decide on appropriate action to protect that member of staff / student we would be grateful if you will answer the following questions.

We accept that these are of a highly personal nature but you can be reassured that they are used routinely in screening blood donors and your answers will remain confidential and will not affect your future treatment.

Below are two lists of questions (one for males and one for females) to establish whether an individual is in a high risk category for infection with a blood borne virus.

**Female Questions Please Tick**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | Have you ever had an HIV test? | Yes |  | No |  |
|  | Is so what was the result? Positive / negative |  |  |  |  |
| 2. | Have you ever had sex with a bisexual man? | Yes |  | No |  |
| 3. | Have you ever paid or been paid for sex? | Yes |  | No |  |
| 4. | Have you had sex with anyone who injected drugs? | Yes |  | No |  |
| 5. | Have you ever had sex with anyone from abroad? | Yes |  | No |  |
|  | If yes, which country were they from? |  |  |  |  |
| 6. | Have you ever injected drugs? | Yes |  | No |  |
| 7. | Have you ever had a blood transfusion? | Yes |  | No |  |
|  | If yes, when and where? |  |  |  |  |
|  |  |  |  |  |  |

**Male Questions Please Tick**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | Have you ever had an HIV test? | Yes |  | No |  |
|  | Is so what was the result? Positive / negative |  |  |  |  |
| 2. | Have you ever had sex with a man? | Yes |  | No |  |
| 3. | Have you ever paid or been paid for sex? | Yes |  | No |  |
| 4. | Have you had sex with anyone who injected drugs? | Yes |  | No |  |
| 5. | Have you ever had sex with anyone from abroad? | Yes |  | No |  |
|  | If yes, which country were they from? |  |  |  |  |
| 6. | Have you ever injected drugs? | Yes |  | No |  |
| 7. | Have you ever had a blood transfusion? | Yes |  | No |  |
|  | If yes, when and where? |  |  |  |  |
|  |  |  |  |  |  |

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_