

Contact name:
First name Surname

Horse Name:



Queensland
Government

APPENDIX: HENDRA VIRUS (CONFIRMED ANIMAL CASE) EXPOSURE ASSESSMENT FORM

PUBLIC HEALTH UNIT

Completed by: Date:/...../.....

Telephone: Fax:

BACKGROUND

This contact history and exposure form is to document interviews with contacts of confirmed Hendra horses, enable qualitative estimates of exposure and to help plan management. The form, especially elements of the exposure assessment, is based on current knowledge of Hendra virus transmission. The document will be reviewed and revised regularly in light of emergent evidence.

CONTACT DETAILS:

UR No:

Name:
First name Surname

Date of birth:/...../..... Age: Years..... Months Sex: Male Female

Name of parent/carer:

Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander Non-Indigenous Unknown

English preferred language: Yes No – specify Ethnicity – specify:

Permanent Address:

.....Postcode:

Home Tel:..... Mob:..... Email:.....

Occupation: Work Telephone:

Temporary Address in Queensland (if different from permanent address) :

..... Postcode:

Telephone:..... Mob:..... Email:.....

General Practitioner: Dr

Address:..... Postcode:

Telephone:..... Fax:..... Email:.....

MEDICAL DETAILS

Has the person become unwell in recent days? Yes No Onset date:/...../.....

Systemic Respiratory Neurological Other – specify

Immunocompromised? Yes No Unknown Details:

Known allergies? Yes No Unknown Details:

Chronic illness? Yes No Unknown Details:

Current Medications:

Other significant history:

INFECTED HORSE DETAILS

Common name and racing/stud name of horse: Location:

Association to horse: Owner Rider Stable hand Vet Farrier Other – specify

EXPOSURE PERIOD

Onset of horse illness:/...../.....

Infectious period for horse: Date:/...../..... to Date:/...../.....
(Onset of symptoms minus 72 hours) (Date of carcass disposal)

Location of exposure: Infected Property Elsewhere – specify:

Has contact ceased? Yes No

Contact name:
First name Surname

Horse Name:

EXPOSURE ASSESSMENT

1. EXPOSURE ASSESSMENT

NOTES FROM CONVERSATION WITH CONTACT

Indicate that from here, the interview will consist of two more parts. First, you will ask the contact to describe in their own words their contact with each horse. You will then ask a series of questions to explore the exposures in detail in the second part. Make notes that you can highlight or refer back to. Try to capture the nature, magnitude, proximity, duration and frequency of exposures to body fluids. Include details of dates and times. Complete a separate page for each horse if necessary.

Vet specific questions: *Can you describe exactly how you examined the horse and what procedures you did? Did you palpate the gums? What samples did you take? What did you do with the syringes and tubes? Did you use any disinfectants? Which? When do you think the horse developed signs of Hendra infection? Do you think any of the other horses on the property have been at risk from this horse?*

Property owner/horse owner/primary horse handler specific questions: *When do you think the horse developed signs of Hendra infection? Do you think any of the other horses on the property have been at risk from this horse? Are there any other people who may have visited the property or touched the horse across the fence?*

COMMENTS:

NOTES FOR FOLLOWING EXPOSURE ASSESSMENT SECTIONS

2. EXPOSURE ASSESSMENT - BIOSECURITY QUEENSLAND STAFF

BIOSECURITY QUEENSLAND STAFF - INFECTION CONTROL including PPE

This section is to be completed first for BQ staff who will be expected to have complete infection control but should be completed to provide epidemiological detail and may trigger memories of incomplete infection control including mishaps.

3. EXPOSURE ASSESSMENT

This section includes three questionnaires, allowing focus on three different aspects of contact with the horse during its illness:

- **General horse handling:** Administer this questionnaire to anyone who undertook activities such as patting, feeding, and grooming, and cleaning stables.
- **Procedures:** Administer this questionnaire to anyone who performed or assisted with procedures such as taking blood or other specimens, veterinary examinations and procedures.
- **Terminal event:** Covers the period of the horse's final event (death by illness or euthanasia). This questionnaire should be administered to everyone who was present within 5m of the horse during this time.

COMPLETE A SEPARATE QUESTIONNAIRE FOR EACH HORSE

Contact name:
First name Surname

Horse Name:

2. EXPOSURE ASSESSMENT - BIOSECURITY QUEENSLAND STAFF

BIOSECURITY QUEENSLAND STAFF - INFECTION CONTROL including PPE

HAND HYGIENE (bare skin)

- Was exposed skin intact? Yes No Unknown
- Was hand hygiene always done after a procedure Yes No Unknown
- Was hand hygiene always done after body substance exposure risk Yes No Unknown
- Was hand hygiene always done after handling the horse Yes No Unknown
- Was hand hygiene always done after handling horse's stable contents? Yes No Unknown
- Was hand hygiene satisfactory? Yes No Unknown

GLOVE USE

- Were gloves always worn before direct contact with horse's blood or body substances, mucous membranes and non-intact skin? Yes No Unknown
- If gloves were used, which type? Latex Nitrile Other *specify* Unknown
- Were gloves always worn before handling horse's equipment and stable contents Yes No Unknown
- Was glove use satisfactory? Yes No Unknown

MASK USE

- If masks were used, which type? e.g. P2, surgical, etc
- Did the wearer of the mask have a beard or other facial hair? Yes No Unknown
- Did the wearer fit check the mask each time one was used? Yes No Unknown
- Has the wearer been fit tested for the respirator? Yes No Unknown
- Was mask use satisfactory? Yes No Unknown

EXPOSURE SELF ASSESSMENT

- Were there any mishaps/lapses with infection control including PPE: Yes No Unknown

1. Nature and cause of mishap – specify

2. Nature of exposure e.g. route of exposure (saliva, blood, respiratory secretions, urine, faeces, other), duration, activity at time or exposure – specify

3. Action in response to mishap/lapse – specify

Subjective overall appraisal of quality of infection control practice including use of adequate PPE: High Medium Low

COMMENTS:

3. EXPOSURE ASSESSMENT

1. GENERAL HORSE HANDLING DURING INFECTIOUS PERIOD

Use 1 column per encounter

Date of activity	Date/...../..... Time(s)	Date...../...../..... Time(s)	Date/...../..... Time(s)
Activity	<input type="checkbox"/> Walked horse on lead <input type="checkbox"/> Held head/other body part <input type="checkbox"/> Patted horse <input type="checkbox"/> Groomed horse <input type="checkbox"/> Fed horse <input type="checkbox"/> Inserted bit <input type="checkbox"/> Kissed muzzle <input type="checkbox"/> Kiss to body <input type="checkbox"/> Cleaned horse equipment <input type="checkbox"/> Cleaned stable <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Other	<input type="checkbox"/> Walked horse on lead <input type="checkbox"/> Held head/ other body part <input type="checkbox"/> Patted horse <input type="checkbox"/> Groomed horse <input type="checkbox"/> Fed horse <input type="checkbox"/> Inserted bit <input type="checkbox"/> Kissed muzzle <input type="checkbox"/> Kiss to body <input type="checkbox"/> Cleaned horse equipment <input type="checkbox"/> Cleaned stable <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Other	<input type="checkbox"/> Walked horse on lead <input type="checkbox"/> Held head/other body part <input type="checkbox"/> Patted horse <input type="checkbox"/> Groomed horse <input type="checkbox"/> Fed horse <input type="checkbox"/> Inserted bit <input type="checkbox"/> Kissed muzzle <input type="checkbox"/> Kiss to body <input type="checkbox"/> Cleaned horse equipment <input type="checkbox"/> Cleaned stable <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Other
1. How long did this activity last? 2. How close was their face to the horse? How long? 3. Horse behaviour & signs	1. Time spent with horsemins / hours 2.metresmins 3.	1. Time spent with horsemins / hours 2.metresmins 3.	1. Time spent with horsemins / hours 2.metresmins 3.
1. Did you get horse body fluid on you? 2. Where? 3. Exposure to horse's equipment or stable contents?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Respiratory secretions <input type="checkbox"/> Saliva <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Faeces <input type="checkbox"/> Foaling fluids <input type="checkbox"/> Other: 2. <input type="checkbox"/> Intact skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Broken skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Clothes 3. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	1. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Respiratory secretions <input type="checkbox"/> Saliva <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Faeces <input type="checkbox"/> Foaling fluids <input type="checkbox"/> Other: 2. <input type="checkbox"/> Intact skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Broken skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Clothes 3. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	1. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Respiratory secretions <input type="checkbox"/> Saliva <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Faeces <input type="checkbox"/> Foaling fluids <input type="checkbox"/> Other: 2. <input type="checkbox"/> Intact skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Broken skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Clothes 3. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Were you using any protective equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.
How and when did you clean up? (e.g. hand hygiene, shower, changed clothes)			

3. EXPOSURE ASSESSMENT

2. PROCEDURES DURING INFECTIOUS PERIOD (LIVE HORSE)

Use 1 column per encounter

Date of activity	Date/...../..... Time(s)	Date...../...../..... Time(s)	Date/...../..... Time(s)
Activity	<input type="checkbox"/> Held head/other body part <input type="checkbox"/> Took blood <input type="checkbox"/> Biopsied mandibular gland <input type="checkbox"/> Intubation <input type="checkbox"/> Endoscopy <i>specify</i> <input type="checkbox"/> Obstetric procedure <input type="checkbox"/> Cleaned vet equipment <input type="checkbox"/> Mouth to mouth resuscitation of foal <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Other	<input type="checkbox"/> Held head/other body part <input type="checkbox"/> Took blood <input type="checkbox"/> Biopsied mandibular gland <input type="checkbox"/> Intubation <input type="checkbox"/> Endoscopy <i>specify</i> <input type="checkbox"/> Obstetric procedure <input type="checkbox"/> Cleaned vet equipment <input type="checkbox"/> Mouth to mouth resuscitation of foal <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Other	<input type="checkbox"/> Held head/other body part <input type="checkbox"/> Took blood <input type="checkbox"/> Biopsied mandibular gland <input type="checkbox"/> Intubation <input type="checkbox"/> Endoscopy <i>specify</i> <input type="checkbox"/> Obstetric procedure <input type="checkbox"/> Cleaned vet equipment <input type="checkbox"/> Mouth to mouth resuscitation of foal <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Other
1. How long did this activity last? 2. How close was their face to the horse? How long? 3. Horse behaviour & signs	1. Time spent with horsemins / hours 2.metresmins 3.	1. Time spent with horsemins / hours 2.metresmins 3.	1. Time spent with horsemins / hours 2.metresmins 3.
1. Did you get horse body fluid on you? 2. Where? 3. Exposure to horse's equipment or stable contents?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Respiratory secretions <input type="checkbox"/> Saliva <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Faeces <input type="checkbox"/> Foaling fluids <input type="checkbox"/> Other: 2. <input type="checkbox"/> Intact skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Broken skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Clothes 3. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	1. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Respiratory secretions <input type="checkbox"/> Saliva <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Faeces <input type="checkbox"/> Foaling fluids <input type="checkbox"/> Other: 2. <input type="checkbox"/> Intact skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Broken skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Clothes 3. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	1. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Respiratory secretions <input type="checkbox"/> Saliva <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Faeces <input type="checkbox"/> Foaling fluids <input type="checkbox"/> Other: 2. <input type="checkbox"/> Intact skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Broken skin <input type="checkbox"/> face <input type="checkbox"/> hands <input type="checkbox"/> other..... <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Clothes 3. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Were you using any protective equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.
How and when did you clean up? (e.g. hand hygiene, shower, changed clothes)			

3. EXPOSURE ASSESSMENT

3. TERMINAL EVENT (from shortly prior to death to disposal of carcass)

Use 1 column per encounter

Date of activity	Date/...../..... Time(s)	Date...../...../..... Time(s)	Date/...../..... Time(s)
Activity	<input type="checkbox"/> Held head/other body part <input type="checkbox"/> Took blood <input type="checkbox"/> Gave drug <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Cleaned up area where horse died <input type="checkbox"/> Cleaned vet equipment. <input type="checkbox"/> Carcass disposal. <input type="checkbox"/> Other	<input type="checkbox"/> Held head/other body part <input type="checkbox"/> Took blood <input type="checkbox"/> Gave drug <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Cleaned up area where horse died <input type="checkbox"/> Cleaned vet equipment. <input type="checkbox"/> Carcass disposal. <input type="checkbox"/> Other	<input type="checkbox"/> Held head/other body part <input type="checkbox"/> Took blood <input type="checkbox"/> Gave drug <input type="checkbox"/> Was within 5m but didn't touch horse <input type="checkbox"/> Cleaned up area where horse died <input type="checkbox"/> Cleaned vet equipment. <input type="checkbox"/> Carcass disposal. <input type="checkbox"/> Other
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Were you using any protective equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Overalls <input type="checkbox"/> Surgical mask <input type="checkbox"/> P2 mask <input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety glasses <input type="checkbox"/> Prescription glasses <input type="checkbox"/> Pow'd air purifying resp.
How and when did you clean up? (e.g. hand hygiene, shower, changed clothes)			

Contact name:
First name Surname

Horse Name:

4. SUMMARY COMMENTS FROM INTERVIEWER

e.g. John had at least 2 face to face contacts (10 mins holding horse , 35 mins doing resp. endoscopy) with extensive exposures to respiratory secretions and blood. No PPE used and hand hygiene of intact skin 35 mins after

5. UNCERTAINTY ASSESSMENT BY INTERVIEWER

Relates to onset of symptoms in the horse (and therefore presumed infectious period) and likelihood of unrecorded exposures

e.g. Good historian. John saw horse daily in the morning. Not clear exactly when signs started but signs present and horse clearly distressed on Tuesday 10 Nov at 0800hrs. No obvious problems with horse when drove past paddock Mon 9 Nov at 1800hrs. No evidence or opportunities for others to have been exposed

6. EXPOSURE ASSESSMENT

There is currently limited evidence about horse-to-human modes of transmission and translating exposure assessments into levels of risk. The following examples of exposure assessments are given to assist decision making by the team. Current epidemiological evidence is that Hendra virus infection has only occurred with those exposures described below as 'High'. If there are multiple exposure pathways (e.g. dermal exposures and mucous membrane exposures) select the highest ranked exposure from the exposure assessment table.

Contact name:
First name Surname

Horse Name:

6. EXPOSURE ASSESSMENT table		
Nature and magnitude of exposures	Assessment	Management
No exposure to dermis and/or mucous membranes	<input type="checkbox"/> Nil	<input type="checkbox"/> Reassurance <input type="checkbox"/> Information <input type="checkbox"/> Serology <input type="checkbox"/> Other testing <input type="checkbox"/> Referred to GP <input type="checkbox"/> Other
Slight to extensive exposures to intact dermis on <3 occasions	<input type="checkbox"/> Negligible	<input type="checkbox"/> Reassurance <input type="checkbox"/> Information <input type="checkbox"/> Serology <input type="checkbox"/> Other testing <input type="checkbox"/> Referred to GP <input type="checkbox"/> Restriction, donation <input type="checkbox"/> Other
Adequate and consistent use of appropriate hand hygiene with intact skin and only skin contact	<input type="checkbox"/> Negligible	<input type="checkbox"/> Reassurance <input type="checkbox"/> Information <input type="checkbox"/> Serology <input type="checkbox"/> Other testing <input type="checkbox"/> Referred to GP <input type="checkbox"/> Restriction, donation <input type="checkbox"/> Other
Adequate and consistent use of PPE without breaches	<input type="checkbox"/> Negligible	<input type="checkbox"/> Reassurance <input type="checkbox"/> Information <input type="checkbox"/> Serology <input type="checkbox"/> Other testing <input type="checkbox"/> Referred to GP <input type="checkbox"/> Restriction, donation <input type="checkbox"/> Other
Slight to extensive exposures to intact dermis on 3 or more occasions	<input type="checkbox"/> Low	<input type="checkbox"/> Reassurance <input type="checkbox"/> Information <input type="checkbox"/> Serology <input type="checkbox"/> Other testing <input type="checkbox"/> Referred to GP <input type="checkbox"/> Restriction, donation <input type="checkbox"/> Other
Slight exposures to mucous membranes or uncovered wounds on 1 occasion	<input type="checkbox"/> Low	<input type="checkbox"/> Reassurance <input type="checkbox"/> Information <input type="checkbox"/> Serology <input type="checkbox"/> Other testing <input type="checkbox"/> Referred to GP <input type="checkbox"/> Restriction, donation <input type="checkbox"/> Other
Moderate exposures to mucous membranes or uncovered wounds on 1 occasion	<input type="checkbox"/> Medium	<input type="checkbox"/> Initial assessment <input type="checkbox"/> Final assessment after discussion with IDP <input type="checkbox"/> Reassurance <input type="checkbox"/> Information <input type="checkbox"/> Serology <input type="checkbox"/> Other testing <input type="checkbox"/> Referred to GP <input type="checkbox"/> Restriction, donation <input type="checkbox"/> Other
Extensive exposures to mucous membranes and/or uncovered wounds and/or needlestick injury on single or multiple occasions without adequate PPE e.g. kissing horse on muzzle, being drenched with oral or respiratory secretions, undertook respiratory tract procedures such as endoscopy or nasal lavage, performed or assisted with post mortem	<input type="checkbox"/> High	<input type="checkbox"/> Initial assessment <input type="checkbox"/> Final assessment after discussion with IDP <input type="checkbox"/> Referred Contact to IDP <input type="checkbox"/> Reassurance <input type="checkbox"/> Information <input type="checkbox"/> Serology <input type="checkbox"/> Other testing <input type="checkbox"/> Referred to GP <input type="checkbox"/> Restriction, donation <input type="checkbox"/> Other

Contact name:
First name Surname

Horse Name:

7. INITIAL EXPOSURE ASSESSMENT (team)

A judgment will need to be made by a public health medical officer/ physician / public health nurse/infection control practitioner as to the extent of exposure with incomplete use of PPE or inappropriate use of infection control

Initial Assessment

Case Officer: PHU: Date: / /

.....

Updates

Case Officer: Date: / /

.....

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Case Officer: Date: / /

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Case Officer: Date: / /

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