

Injecting Technique Questionnaire

Client name: _____ Sex: M / F Worker initials: _____

Daisy No. _____ Date: _____

1. Have you experienced any of these problems due to injecting

(a) Over the last 6 months?

(b) In the past? (tick all that apply)

- | (a) | (b) | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Blocked/collapsed veins |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulation problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Dirty hit – List symptoms experienced: |
| <input type="checkbox"/> | <input type="checkbox"/> | Injected into a artery |
| <input type="checkbox"/> | <input type="checkbox"/> | Numb patches |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain at the injection site |
| <input type="checkbox"/> | <input type="checkbox"/> | Citric burns |
| <input type="checkbox"/> | <input type="checkbox"/> | Abscess/infection at injection site |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers/open sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Cellulitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood infection (Septicemia) |
| <input type="checkbox"/> | <input type="checkbox"/> | DVT (Deep Vein Thrombosis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocarditis |
| <input type="checkbox"/> | <input type="checkbox"/> | Other – please specify: |

2. Did you get medical help for any of these problems?

Yes

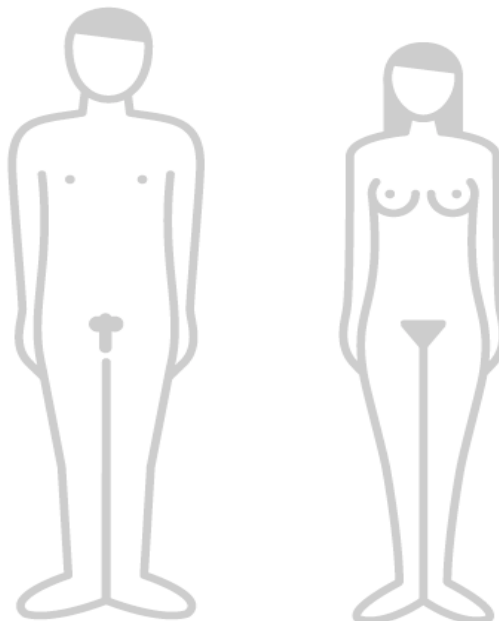
No

Details:

3. Where do you inject?

(Please mark diagram with x's)

(Please circle diagram with past sites)



4. Where do you get your injecting equipment?

Pharmacy Drugs agency Treatment centre other – please specify.....

5. What source of water do you use for injection?

6. What type of filter do you use for injection?

7. What acidifiers do you use?

Citric acid vitamin C lemon juice vinegar other

8. What do you use to cook your drugs in?

Spoon stericup can other

9. If you use a can, where do you get this?

Bin buy a can other

10. Do you wash the can before use?

Yes No

11. Do you crush the can with your foot?

Yes No

12. Do you wash your hands before cooking up/injecting?

Yes No

13. Do you ever help others to inject / inject others?

Yes No

14. Do you allow others to inject for you?

Yes No

15. If yes, do they wash their hands before injecting you?

Yes No

16. Do you allow others to help you / prepare your drugs?

Yes No

17. If yes, do they was their hands before preparing the drugs?

Yes No

18. If yes, do they use new / sterile equipment?

Yes No

19. Do you suck equipment when preparing / injecting drugs?

Yes No

20. Have you ever let someone else fill their syringe with a syringe you had already used / prepared for injecting?

Yes No

21. Have you filled your syringe from another syringe that had already been used / prepared for injection by someone else?

Yes No

22. Have you shared with/lent others any of the following equipment? (tick)

| | Never | In the past | In the past month |
|------------|-------|-------------|-------------------|
| Water | | | |
| Filter | | | |
| Spoon | | | |
| Needle | | | |
| Barrel | | | |
| Swab | | | |
| Tourniquet | | | |
| Crack pipe | | | |

23. Do you reuse injecting equipment?

Yes No Own Others

24. If yes, please specify which equipment:

Filters Water Needles Barrels Spoons

25. Do you use the same water for washing out the syringe as you do for the injection prep?

Yes No

26. Have you come into contact with someone else's blood?

(Fights, accidents, injecting)

Yes No

27. Do you wash/swab the injecting site before injecting?

Yes No

28. Do you use a sterile/new needle and syringe for each injection?

Yes No

29. How do you dispose of your used equipment?

Cin bin needle exchange clinic/treatment centre other- please specify
