Blood and Body Fluid Exposure Report

EPINet™ FOR MICROSOFT® ACCESS
EXPOSURE PREVENTION► INFORMATION NETWORK►

Last name: _____ **First name:** _____

Email: _____

Injury ID: *(for office use only)* B_____ *Completed by:* _____

Facility ID/ name: _____ _____ *Date reported*: _____

1. Date of incident: _____/_____/_____ **2. Time of incident:** _____:_____

3. Department where incident occurred: _____ **4) Home department:** _____

5. What is the job category of the exposed worker: *(check one box only)*

- ☐ 1 Doctor *(attending/staff)*; specify specialty _____
- ☐ 2 Doctor *(intern/resident/fellow)* specify specialty _____
- ☐ 3 Medical student
- ☐ 4 Nurse--**TICK ONE**═══►
  - ☐ 1 Staff/Enrolled
  - ☐ 2 Sister/Charge
  - ☐ 3 Specialist
  - ☐ 4 Consultant
  - ☐ 5 Agency (*temporary staff only)*
- ☐ 24 Midwife/Birth assistant
- ☐ 5 Nursing student
- ☐ 18 Ward assistant
- ☐ 6 Respiratory therapist
- ☐ 7 Surgery attendant
- ☐ 8 Other attendant
- ☐ 9 Phlebotomist/Venipuncture/IV team
- ☐ 10 Clinical laboratory worker
- ☐ 11 Technologist *(non-lab)*
- ☐ 12 Dentist
- ☐ 13 Dental hygienist
- ☐ 14 Housekeeper
- ☐ 19 Laundry worker
- ☐ 20 Security
- ☐ 16 Paramedic
- ☐ 17 Other student
- ☐ 17 Other, describe: _____

6. Where did the exposure occur? *(check one box only)*

- ☐ 1 Patient bedside
- ☐ 2 Outside patient room *(hallway, nurses station, etc.*)
- ☐ 3 Casualty/Emergency room
- ☐ 4 Intensive/Critical care unit: specify type:_____
- ☐ 5 Operating room/Recovery
- ☐ 6 Consulting room/OPD/Clinic
- ☐ 7 Blood bank
- ☐ 8 Venipuncture center
- ☐ 9 Dialysis facility *(hemodialysis and peritoneal dialysis)*
- ☐ 10 Procedure room *(injection/suture/POP/x-ray/EKG/etc.)*
- ☐ 11 Clinical laboratories
- ☐ 12 Autopsy/Pathology
- ☐ 13 Service/Utility *(laundry,central supply,loading dock,etc.)*
- ☐ 16 Labor and Delivery room
- ☐ 17 Home-care
- ☐ 14 Other, describe: _____

7. Was the source patient identifiable? *(check one box only)*

☐ 1 Yes ☐ 2 No ☐ 3 Unknown ☐ 4 Not applicable

8. Which body fluids were involved in the exposure? *(check all that apply)*

- ☐ Blood or blood products
- ☐ Vomit
- ☐ Sputum
- ☐ Saliva
- ☐ CSF
- ☐ Peritoneal fluid
- ☐ Pleural fluid
- ☐ Amniotic fluid/Liquor
- ☐ Urine
- ☐ Other, describe: _____

8a. Was the body fluid visibly contaminated with blood? ☐ Yes ☐ No ☐ Unknown

9. Was the exposed part? *(check all that apply)*

- ☐ Intact skin
- ☐ Non-intact skin
- ☐ Eyes (*conjunctiva*)
- ☐ Nose (*mucosa*)
- ☐ Mouth (*mucosa*)
- ☐ Other, describe: _____

10. Did the blood or body fluid? *(check all that apply)*

- ☐ Touch unprotected skin
- ☐ Touch skin between gap in protective garments
- ☐ Soak through barrier garment or protective garment
- ☐ Soak through clothing

11. Which barrier garments were worn at the time of exposure? *(check all that apply)*

- ☐ None
- ☐ Single pair latex/vinyl/nitrile gloves
- ☐ Double pair latex/vinyl/nitrile gloves
- ☐ Goggles
- ☐ Eyeglasses *(not a protective item)*
- ☐ Eyeglasses with side shields
- ☐ Face shield
- ☐ Surgical mask
- ☐ Surgical gown
- ☐ Plastic apron
- ☐ Lab coat, cloth *(not a protective garment)*
- ☐ Lab coat, other
- ☐ Other, describe: _____

12. Was the exposure the result of? *(check one box only)*

- ☐ 1 Direct patient contact
- ☐ 2 Specimen container leaked/spilled
- ☐ 3 Specimen container broke
- ☐ 4 IV tubing/bag/pump leaked/broke
- ☐ 10 Feeding/Ventilator/Other tube separated/leaked/splashed. Specify tubing: _____
- ☐ 5 Other body fluid container spilled/leaked
- ☐ 6 Touched contaminated equipment/surface
- ☐ 7 Touched contaminated drapes/sheets/gowns, etc.
- ☐ 8 Unknown
- ☐ 9 Other, describe: _____

13. For how long was the blood or body fluid in contact with your skin or mucous membranes? *(check one)*

- ☐ 1 Less than 5 minutes
- ☐ 2 5-14 minutes
- ☐ 3 15 minutes to 1 hour
- ☐ 4 More than 1 hour

14. How much blood/body fluid came in contact with your skin or mucous membranes? *(check one)*

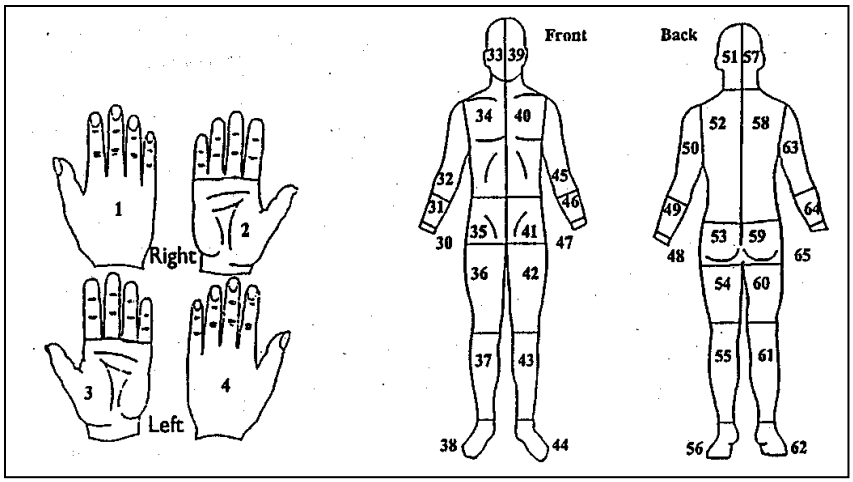
- ☐ 1 Small amount *(up to 5 ml)*
- ☐ 2 Moderate amount *(up to 50 ml)*
- ☐ 3 Large amount *(more than 50 ml)*

15. Write up to 3 numbers indicating the location of exposed body parts.

Area 1: _____

Area 2: _____

Area 3: _____



16. Have you been vaccinated for Hepatitis B? *(check one box only)*

☐ 1 Yes, fully, 3 doses ☐ 2 Yes, partially, 1 or 2 doses ☐ 3 No ☐ 4 Not applicable

17. Describe the circumstances leading to this exposure:

_____

_____

_____

_____

_____

_____

Cost:

_____ Lab charges (Hb, HCV, HIV, other)
_____ *Healthcare worker*
_____ *Source*
_____ Treatment prophylaxis (HBIG, Hb vaccine, tetanus, other)
_____ *Healthcare worker*
_____ *Source*
_____ Service charges (Emergency Dept, Employee Health, other)
_____ Other costs (Worker's Comp, surgery, other)
_____ TOTAL (round to nearest dollar)

Is this incident government reportable? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

If yes, days away from work? _____

Days of restricted work activity? _____

Does this incident meet the medical device reporting criteria? (Yes if a device defect caused serious injury necessitating medical or surgical intervention, or death occurred within 10 works days of incident.)

☐ 1 Yes ☐ 2 No ☐ 3 Unknown