

# Blood and Body Fluid Exposure Report



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12/2014

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)

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

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

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

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

- |                                |                               |                                    |   |
|--------------------------------|-------------------------------|------------------------------------|---|
| <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No | <input type="checkbox"/> 3 Unknown | <input type="checkbox"/> 4 Not applicable |
|--------------------------------|-------------------------------|------------------------------------|---|

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

- |  |   |
|--|---|
| <input type="checkbox"/> Blood or blood products | <input type="checkbox"/> Peritoneal fluid       |
| <input type="checkbox"/> Vomit                   | <input type="checkbox"/> Pleural fluid          |
| <input type="checkbox"/> Sputum                  | <input type="checkbox"/> Amniotic fluid/Liquor  |
| <input type="checkbox"/> Saliva                  | <input type="checkbox"/> Urine                  |
| <input type="checkbox"/> CSF                     | <input type="checkbox"/> Other, describe: _____ |

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> Intact skin                 | <input type="checkbox"/> Nose ( <i>mucosa</i> )  |
| <input type="checkbox"/> Non-intact skin             | <input type="checkbox"/> Mouth ( <i>mucosa</i> ) |
| <input type="checkbox"/> Eyes ( <i>conjunctiva</i> ) | <input type="checkbox"/> Other, describe: _____  |

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

- |  |   |
|--|---|
| <input type="checkbox"/> Touch unprotected skin                        | <input type="checkbox"/> Soak through barrier garment or protective garment |
| <input type="checkbox"/> Touch skin between gap in protective garments | <input type="checkbox"/> Soak through clothing                              |

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

- |  |  |
|--|--|
| <input type="checkbox"/> None  | <input type="checkbox"/> Surgical mask                                       |
| <input type="checkbox"/> Single pair latex/vinyl/nitrile gloves      | <input type="checkbox"/> Surgical gown                                       |
| <input type="checkbox"/> Double pair latex/vinyl/nitrile gloves      | <input type="checkbox"/> Plastic apron                                       |
| <input type="checkbox"/> Goggles                                     | <input type="checkbox"/> Lab coat, cloth ( <i>not a protective garment</i> ) |
| <input type="checkbox"/> Eyeglasses ( <i>not a protective item</i> ) | <input type="checkbox"/> Lab coat, other                                     |
| <input type="checkbox"/> Eyeglasses with side shields                | <input type="checkbox"/> Other, describe: _____                              |
| <input type="checkbox"/> Face shield                                 |  |

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)

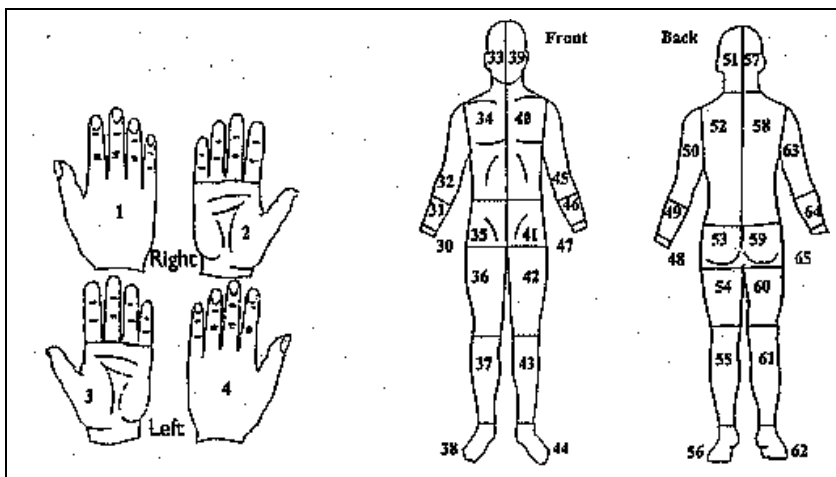
- ☐ 1 Small amount (up to 5 ml)  
☐ 2 Moderate amount (up to 50 ml)  
☐ 3 Large amount (more than 50 ml)

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:**

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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