Blood and Body Fluid Exposure Report

(Non-Sharps Exposures)

INTERNATIONAL SAFETY CENTER

EPINet®

EXPOSURE PREVENTION ► INFORMATION NETWORK ►

Last name: _____ First name: _____

Email address: _____

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

Access 2018 US 6/2019

1. Date of exposure: ☐☐ ☐☐ ☐☐☐☐ **2. Time of exposure:** ☐☐ ☐☐

3. Home/Employing department/Cost center: _____

3a, Department where injury occurred (optional): _____

4. 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 _____
- ☐ 22 Physician's assistant
- ☐ 3 Medical student
- ☐ 4 Nurse: specify ═══►
  - ☐ 1 R.N.
  - ☐ 2 L.P.N./L.V.N.
  - ☐ 3 N.P.
  - ☐ 4 C.R.N.A.
  - ☐ 5 Midwife
- ☐ 5 Nursing student
- ☐ 18 C.N.A./H.H.A.
- ☐ 6 Respiratory therapist
- ☐ 7 Surgery tech/attendant
- ☐ 8 Other attendant
- ☐ 9 Phlebotomist/Venipuncture
- ☐ 21 IV team
- ☐ 10 Clinical laboratory worker
- ☐ 11 Technologist *(non-lab)*
- ☐ 12 Dentist
- ☐ 13 Dental hygienist
- ☐ 14 EVS/Housekeeper
- ☐ 19 Laundry worker
- ☐ 20 Security
- ☐ 16 EMT/Paramedic/First Responder
- ☐ 17 Other student
- ☐ 15 Other, describe: _____

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

- ☐ 1 Patient room
- ☐ 2 Outside patient room *(hallway, nurses station, etc.)*
- ☐ 3 Emergency department
- ☐ 4 Intensive/Critical care unit: specify type: _____
- ☐ 5 Operating room/Recovery
- ☐ 6 Outpatient clinic/Office
- ☐ 7 Blood bank
- ☐ 8 Venipuncture center
- ☐ 9 Dialysis facility *(hemodialysis and peritoneal dialysis)*
- ☐ 10 Procedure room *(x-ray, EKG,etc)*
- ☐ 11 Clinical laboratories
- ☐ 12 Autopsy/Pathology
- ☐ 13 Service/Utility *(laundry,central supply,sterile processing,waste,etc)*
- ☐ 16 Labor and delivery room
- ☐ 17 Home-care
- ☐ 14 Other, describe: _____

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

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

7. Which of the patient's 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
- ☐ Urine
- ☐ Other, describe: _____

7a, Was the body fluid visibly contaminated with blood? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

8. Was the worker's exposed part? (check all that apply)

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

9. 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/uniform

9a. Did the exposure result in the need to remove a garment and obtain a replacement? ☐ 1 Yes ☐ 2 No

10. Which barrier garments and/or personal protective equipment were worn at the time of exposure? (check all that apply)

- ☐ Single pair latex/vinyl/nitrile gloves
- ☐ Double pair latex/vinyl/nitrile gloves
- ☐ Eyeglasses *(not a protective item)*
- ☐ Eyeglasses with side shields
- ☐ Protective eyewear/Goggles
- ☐ Face shield
- ☐ Surgical mask
- ☐ Respirator
- ☐ Gowns: Surgical, isolation, chemotherapy
- ☐ Plastic apron
- ☐ Lab coat/Scrub jacket *(not protective garments)*
- ☐ Scrubs/Uniform *(not protective garments)*
- ☐ Other specialized garment worn as protection
- ☐ Other, describe: _____

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

- ☐ 1 During patient procedure, describe _____
- ☐ 11 Patient initiated (spitting/biting/vomiting etc.)
- ☐ 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: _____

11a. Did the incident result in an exposure to a hazardous drug (e.g. chemotherapy, antineoplastic)? ☐ 1. Yes ☐ 2. No ☐ 3. Unknown

11b. If equipment failure, please specify: **Equipment type:** _____

Manufacturer: _____

12. For how long was the blood or body fluid In contact with your skin or mucous membranes? (check one box only)

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

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

- ☐ 1 Small amount (up to 5 cc, or up to 1 teaspoon)
- ☐ 2 Moderate amount (up to 50 cc, or up to quarter cup)
- ☐ 3 Large amount (more than 50 cc)

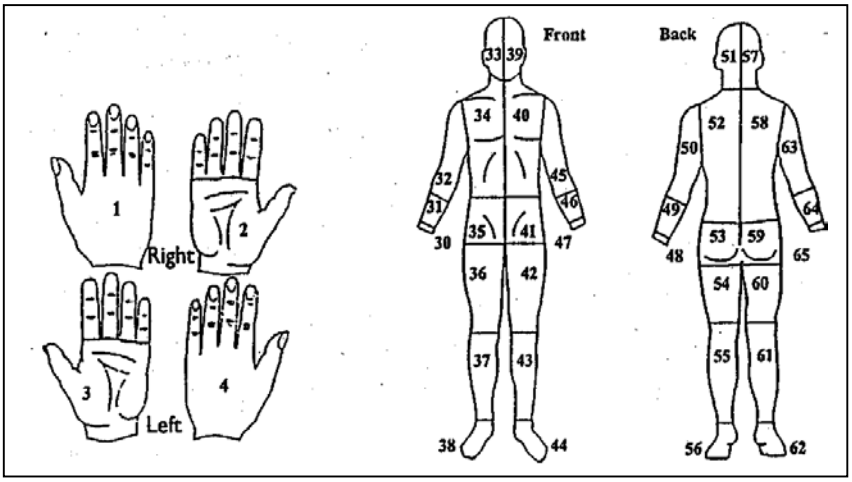
14. Location of the exposure:

Write the number of the locations of up to three exposed body parts in the blanks below.

Largest area of exposure: _____

Middle area of exposure: _____

Smallest area of exposure: _____



15. Employment status of injured worker:

- ☐ 1 Employee
- ☐ 2 Temp/Contract
- ☐ 3 Student
- ☐ 4 Volunteer
- ☐ 5 Non-employee/Practitioner
- ☐ 6 Other

16. Describe the circumstances leading to this exposure: *(please note if a device malfunction was involved)***:**

_____
_____
_____
_____
_____

Is this incident OSHA recordable? *(for office use only)*

☐ 1 Yes ☐ 2 No ☐ 3 Unknown

If yes:
Days away from work: _____
Days of restricted work activity: _____

Was prophylaxis provided? *(for office use only)* ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

Does this incident meet the FDA 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.) ? *(for office use only)*

☐ 1 Yes *(If yes, follow FDA reporting protocol.)* ☐ 2 No ☐ 3 Unknown

See following page to enter Cost data.

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Cost: *(optional, for office use only)*

	Lab charges (HBV, HCV, HIV, other)
_____	Healthcare worker
_____	Source
	Treatment/Prophylaxis (HBIG, HBV vaccine, tetanus, other)
_____	Healthcare worker
_____	Source
_____	Service charges (Emergency Dept, Employee Health, other)
_____	Other costs (Worker's Comp, surgery, other)
_____	Paid Time Off
_____	TOTAL

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