Blood and Body Fluid Exposure Report

EPINet™ FOR MICROSOFT® ACCESS

EXPOSURE PREVENTION ► INFORMATION NETWORK ►

V1.2/Canada 2/2002

Last Name: _____ First Name: _____

Exposure ID: *(for office use only)* **B**_____ Facility ID: *(for office use only)* _____

1) Date of Exposure: ☐☐ ☐☐ ☐☐☐☐ **2) Time of Exposure:** ☐☐ ☐☐

3) Department where Incident Occurred: _____

4) Home Department: _____

5) What is the Job Category of the Injured Worker: (check one box only)

- ☐ 1 Doctor *(attending/staff)*; specify specialty _____
- ☐ 2 Doctor *(intern/resident/fellow)* specify specialty _____
- ☐ 3 Medical Student
- ☐ 4 Nurse: specify ⟹ ☐ RN ☐ LPN/CNA/HHA ☐ NP ☐ CRNA
- ☐ 5 Nursing Student
- ☐ 21 Midwife
- ☐ 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
- ☐ 15 Other, describe: _____

6) 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,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
- ☐ Urine
- ☐ Other, Describe: _____

Was the body fluid visibly contaminated with blood? ☐ 1 Yes ☐ 2 No ☐ 3 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)

- ☐ Single Pair Latex/Vinyl Gloves
- ☐ Double pair Latex/Vinyl 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: _____

If Equipment Failure, Please Specify: **Equipment Type**: _____

Manufacturer: _____

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 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)

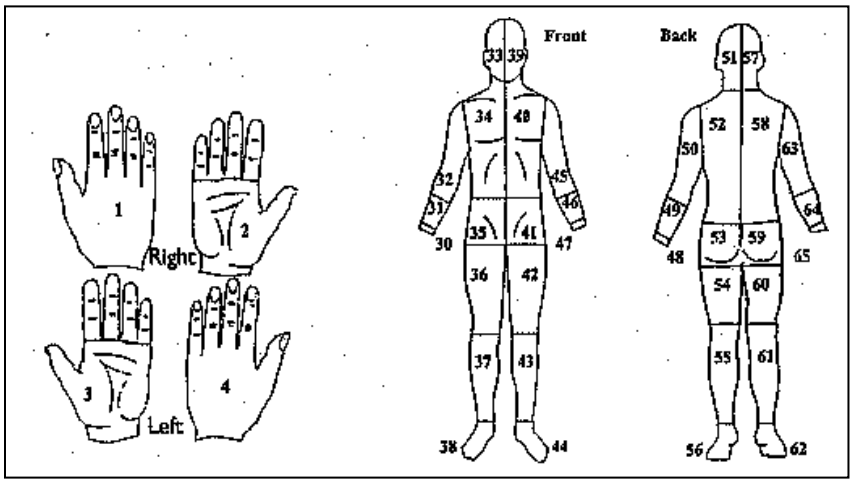
15) Location of the Exposure:

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

Largest area of exposure: _____

Medium area of exposure: _____

Smallest area of exposure: _____



16) Describe the Circumstances Leading to this Exposure *(please note if a device malfunction was involved)*:

_____
_____
_____
_____
_____

17) For Injured Worker: Do you have an Opinion that any other Engineering Control, Administrative or Work Practice could have prevented the Injury? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

Describe: _____
_____
_____
_____

Cost:

Lab charges *(Hb, HCV, HIV, other tests)*
_____ 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 WCB reportable? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

If Yes, Days Away from Work? _____
Days of Restricted Work Activity? _____