

Blood and Body Fluid Exposure Report

EPINet™

FOR MICROSOFT® ACCESS
EXPOSURE PREVENTION
INFORMATION NETWORK▶

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Last name: _____ First name: _____

Incident ID: (office use only) _____ Facility ID: (office use only) _____ Birthdate: _____

1) Date of injury: _____ 2) Date reported: _____

3) Department where incident occurred: _____

4) Home/employing department: _____ Time of incident: _____

5) Healthcare worker job category: (tick one box only)

- | | |
|---|---|
| <input type="checkbox"/> 1 Doctor (<i>Medical Officer</i>) specify specialty _____ | <input type="checkbox"/> 10 Laboratory/pathology staff |
| <input type="checkbox"/> 2 Doctor (<i>intern</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: specify <input checked="" type="checkbox"/> 1 RN <input type="checkbox"/> 4 APN | <input type="checkbox"/> 13 Dental therapist/nurse |
| <input type="checkbox"/> 5 Nursing student <input type="checkbox"/> 2 EN <input type="checkbox"/> 5 APN(N+M) | <input type="checkbox"/> 21 CSSD/TSSU staff |
| <input type="checkbox"/> 18 Nursing assistant <input type="checkbox"/> 3 Officer <input type="checkbox"/> 6 LVCN | <input type="checkbox"/> 14 Housekeeping |
| <input type="checkbox"/> 24 Midwife | <input type="checkbox"/> 19 Laundry worker |
| <input type="checkbox"/> 22 Community health staff/allied health staff | <input type="checkbox"/> 16 Ambulance staff/paramedic |
| <input type="checkbox"/> 8 Orderly/ward/trolley person | <input type="checkbox"/> 17 Other student |
| <input type="checkbox"/> 9 Phlebotomist/Venipuncture/IV team | |
| <input type="checkbox"/> 23 Anaesthetic/perfusion tech | <input type="checkbox"/> 15 Other, specify: _____ |

6) Where did the injury occur? (tick one box only)

- | | |
|--|---|
| <input type="checkbox"/> 1 Ward/nursery/patient's room | <input type="checkbox"/> 9 Dialysis facility (<i>haemodialysis and peritoneal dialysis</i>) |
| <input type="checkbox"/> 19 Dental cubicle | <input type="checkbox"/> 10 Procedure areas (<i>imaging, angiography, cardiac cath, etc</i>) |
| <input type="checkbox"/> 2 Outside patient room (<i>hallway, nurses station, etc.</i>) | <input type="checkbox"/> 11 Pathology/clinical laboratories |
| <input type="checkbox"/> 3 Emergency department | <input type="checkbox"/> 12 Autopsy |
| <input type="checkbox"/> 4 Intensive/critical care: specify type: _____ | <input type="checkbox"/> 13 Nonclinical-service/utility (<i>CSSD, laundry, supply, loading dock, etc</i>) |
| <input type="checkbox"/> 5 Operating room/anaesthetic/cleanup/theatre/recovery | <input type="checkbox"/> 16 Delivery/labour ward |
| <input type="checkbox"/> 6 Community clinic/outpatient clinic | <input type="checkbox"/> 17 Patient's home |
| <input type="checkbox"/> 8 Blood collection room | <input type="checkbox"/> 14 Other, specify: _____ |

7) Was the source patient identifiable? (tick one box only)

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

8) To which body fluids was the healthcare worker exposed? (tick all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood or blood products | <input type="checkbox"/> CSF | <input type="checkbox"/> Urine |
| <input type="checkbox"/> Vomit | <input type="checkbox"/> Peritoneal fluid | |
| <input type="checkbox"/> Sputum | <input type="checkbox"/> Pleural fluid | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Saliva | <input type="checkbox"/> Amniotic fluid | (includes semen, breastmilk, etc.) |

Was the body fluid visibly stained with blood? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

9) Which body surfaces of the healthcare worker were involved? (tick 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, specify: _____ |

10) Did the blood or body fluid: (tick 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? (tick all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Gloves, single pair | <input type="checkbox"/> Surgical mask |
| <input type="checkbox"/> Gloves, double pair | <input type="checkbox"/> Surgical gown |
| <input type="checkbox"/> Goggles | <input type="checkbox"/> Plastic apron |
| <input type="checkbox"/> Eyeglasses (<i>not a protective item</i>) | <input type="checkbox"/> Lab coat/gown, cloth (<i>permeable-not protective</i>) |
| <input type="checkbox"/> Eyeglasses with side shields | <input type="checkbox"/> Lab coat/gown, other |
| <input type="checkbox"/> Face shield | <input type="checkbox"/> Other, specify: _____ |

12) What was the exposure the result of? (tick one box only)

- | | |
|---|---|
| <input type="checkbox"/> 1 Direct patient contact | <input type="checkbox"/> 5 Other body fluid container spilled/leaked |
| <input type="checkbox"/> 2 Specimen container leaked/spilled | <input type="checkbox"/> 6 Touched contaminated equipment/surface |
| <input type="checkbox"/> 3 Specimen container broke | <input type="checkbox"/> 7 Touched contaminated drapes/sheets/gowns, etc. |
| <input type="checkbox"/> 4 IV tubing/bag/pump leaked/broke | <input type="checkbox"/> 8 Unknown |
| <input type="checkbox"/> 10 Feeding/ventilator/other tube separated/leaked/splashed | <input type="checkbox"/> 11 Assault or non percutaneous bite |
| Specify tubing: _____ | <input type="checkbox"/> 9 Other, specify: _____ |

If equipment failure, please specify: _____

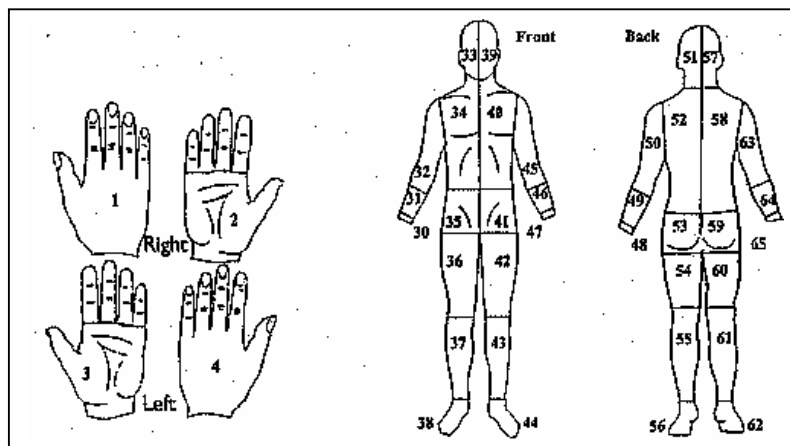
Equipment type: _____

Manufacturer: _____

- 14) How much blood/body fluid came in contact with healthcare worker's skin or mucous membranes? (tick one)**
- ☐ 1 Small amount (up to 5 ml, or up to 1 teaspoon)
- ☐ 2 Moderate amount (up to 50ml, or up to quarter cup)
- ☐ 3 Large amount (more than 50 ml)

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

Smallest area of exposure: _____



-
-
-
-

- Describe: _____
- _____
- _____

_____ **Lab charges** (HBV, HCV, HIV, other tests)
 _____ Healthcare worker
 _____ Source
 _____ **Treatment prophylaxis** (HBIG, Hepatitis vaccines, 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 defective medical device reporting required? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown