

Blood and Body Fluid Exposure Report



EXPOSURE PREVENTION
INFORMATION NETWORK

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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)

- | | |
|---|---|
| <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: specify <input type="checkbox"/> 1 RN | <input type="checkbox"/> 13 Dental Hygienist |
| <input type="checkbox"/> 5 Nursing Student <input type="checkbox"/> 2 LPN | <input type="checkbox"/> 14 Housekeeper |
| <input type="checkbox"/> 18 CNA/HHA <input type="checkbox"/> 3 NP | <input type="checkbox"/> 19 Laundry Worker |
| <input type="checkbox"/> 6 Respiratory Therapist <input type="checkbox"/> 4 CRNA | <input type="checkbox"/> 20 Security |
| <input type="checkbox"/> 7 Surgery Attendant <input type="checkbox"/> 5 Midwife | <input type="checkbox"/> 16 Paramedic |
| <input type="checkbox"/> 8 Other Attendant | <input type="checkbox"/> 17 Other Student |
| <input type="checkbox"/> 9 Phlebotomist/Venipuncture/IV Team | <input type="checkbox"/> 15 Other, describe: _____ |

6) Where Did the Exposure Occur? (check one box only)

- | | |
|--|---|
| <input type="checkbox"/> 1 Patient Room | <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>x-ray, EKG, etc</i>) |
| <input type="checkbox"/> 3 Emergency Department | <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 Outpatient Clinic/Office | <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)

- 1 Yes 2 No 3 Unknown 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 |
| <input type="checkbox"/> Saliva | <input type="checkbox"/> Urine |
| <input type="checkbox"/> CSF | <input type="checkbox"/> Other, Describe: _____ |

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"/> Single Pair Latex/Vinyl Gloves | <input type="checkbox"/> Surgical Mask |
| <input type="checkbox"/> Double pair Latex/Vinyl Gloves | <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, Cloth (<i>not a protective garment</i>) |
| <input type="checkbox"/> Eyeglasses with Side shields | <input type="checkbox"/> Lab Coat, Other |
| <input type="checkbox"/> Face shield | <input type="checkbox"/> Other, Describe: _____ |

12) Was the Exposure the Result of: (check 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/Spashed.
Specify Tubing: _____ | <input type="checkbox"/> 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)

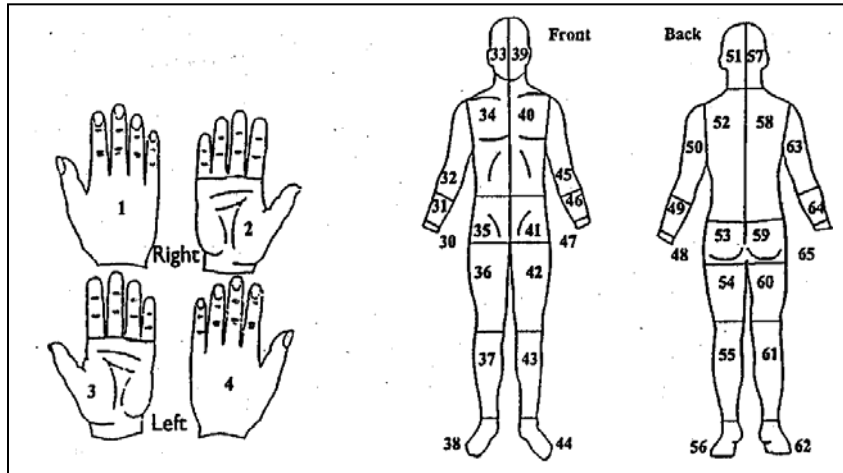
15) Location of the Exposure:

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

Largest area of exposure: _____

Middle 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 OSHA reportable? 1 Yes 2 No 3 Unknown

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

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.)

- 1 Yes (If Yes, follow FDA reporting protocol)
- 2 No