

Blood and Body Fluid Exposure Report

EPINet®

Last name: _____ First name: _____
Email address: _____

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

1) Date of exposure: 2) Time of exposure:

3) Department where incident occurred: _____

4) Home/Employing 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: specify <input type="checkbox"/> 1 R.N. | <input type="checkbox"/> 13 Dental hygienist |
| <input type="checkbox"/> 5 Nursing student <input type="checkbox"/> 2 L.P.N. | <input type="checkbox"/> 14 Housekeeper |
| <input type="checkbox"/> 18 C.N.A./H.H.A. <input type="checkbox"/> 3 N..P | <input type="checkbox"/> 19 Laundry worker |
| <input type="checkbox"/> 6 Respiratory therapist <input type="checkbox"/> 4 C.R.N.A. | <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: _____ |

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"/> 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, describe: _____ |
| <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/splashed. | <input type="checkbox"/> 9 Other, describe: _____ |
- Specify tubing: _____

FOR MICROSOFT ACCESS
EXPOSURE PREVENTION
INFORMATION NETWORK

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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)

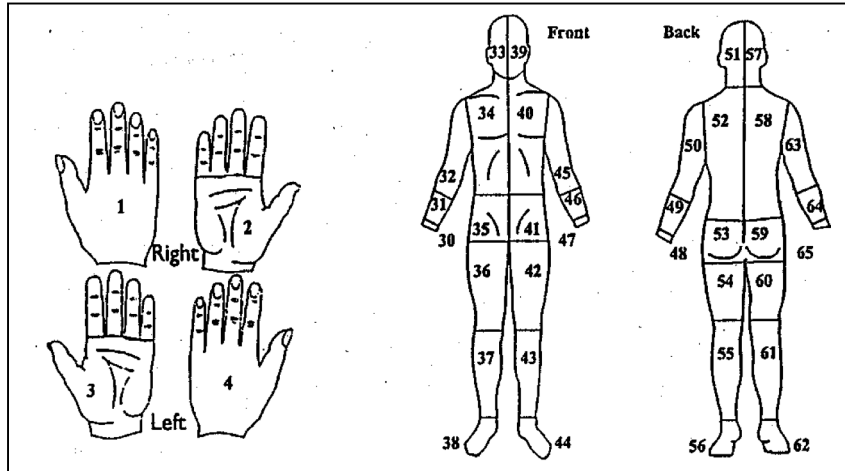
15) Location of the exposure:

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 exposed worker: Do you have an opinion that any other engineering control, administrative or work practice could have prevented the exposure? 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
- 3 Unknown