

# Blood and Body Fluid Exposure Report



Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Injury ID: (for office use only) **B** \_\_\_\_\_ Completed by: \_\_\_\_\_

Facility name: \_\_\_\_\_

Teaching/Regional hospital  Polyclinic  Health post  Other, describe: \_\_\_\_\_

1) **Date of exposure:** \_\_\_\_/\_\_\_\_/\_\_\_\_ 2) **Time exposure:** \_\_\_\_:\_\_\_\_

3) **Department where exposure occurred:** \_\_\_\_\_ 4) **Home department:** \_\_\_\_\_

5) **What is the job category of the exposed worker?** (check one box only)

- |  |   |
|--|---|
| <input type="checkbox"/> 1 Doctor ( <i>specialist/consultant</i> ); specialty _____        | <input type="checkbox"/> 10 Clinical laboratory worker      |
| <input type="checkbox"/> 2 Doctor ( <i>resident/SMO/MO/House officer</i> ) specialty _____ | <input type="checkbox"/> 11 Technologist ( <i>non lab</i> ) |
| <input type="checkbox"/> 3 Medical student   | <input type="checkbox"/> 12 Dentist                         |
| <input type="checkbox"/> 24 Midwife/Birth attendant  | <input type="checkbox"/> 16 Paramedic                       |
| <input type="checkbox"/> 4 Nurse =====> <input type="checkbox"/> 1 Registered              | <input type="checkbox"/> 14 Housekeeper                     |
| <input type="checkbox"/> 5 Nursing student <input type="checkbox"/> 2 Midwife              | <input type="checkbox"/> 19 Laundry worker                  |
| <input type="checkbox"/> 17 Other student <input type="checkbox"/> 3 Enrolled              | <input type="checkbox"/> 20 Security                        |
| <input type="checkbox"/> 18 Ward assistant <input type="checkbox"/> 4 Enrolled asst.       | <input type="checkbox"/> 15 Other, describe: _____          |
| <input type="checkbox"/> <input type="checkbox"/> 5 Agency staff                           |   |

6) **Where did the exposure occur?** (check one box only)

- |  |  |
|--|--|
| <input type="checkbox"/> 1 Patient bedside   | <input type="checkbox"/> 9 Dialysis facility ( <i>hemodialysis and peritoneal dialysis</i> )       |
| <input type="checkbox"/> 2 Outside patient area ( <i>hallway, nurses station, etc.</i> ) | <input type="checkbox"/> 10 Procedure room ( <i>injection/suture/POP/x-ray/EKG/etc.</i> )          |
| <input type="checkbox"/> 3 Casualty/Emergency room                                       | <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 Consulting room/OPD/Clinic                                    | <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/Liquor  |
| <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/nitrile gloves      | <input type="checkbox"/> Surgical mask                                       |
| <input type="checkbox"/> Double pair latex/vinyl/nitrile 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/splashed.<br>Specify tubing: _____ | <input type="checkbox"/> 9 Other, describe: _____                         |

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6/2013

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)

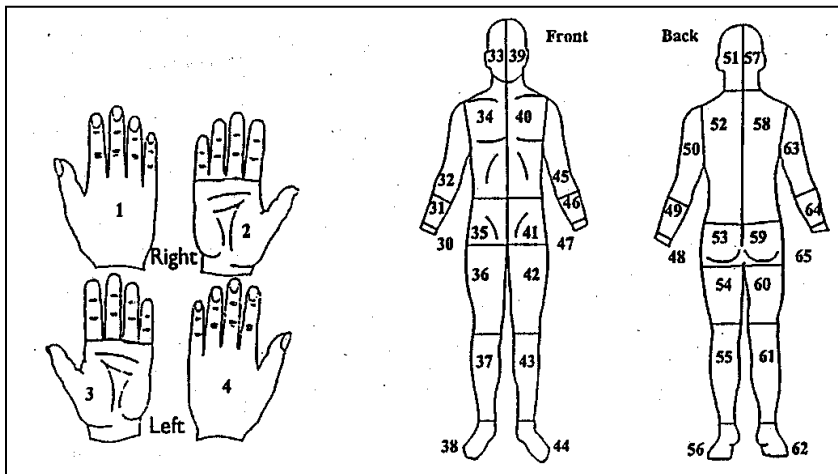
- 1 Small amount (up to 5 ml)
- 2 Moderate amount (up to 50 ml)
- 3 Large amount (more than 50 ml)

15) **Write up to 3 numbers indicating the location of exposed body parts.**

Area 1: \_\_\_\_\_

Area 2: \_\_\_\_\_

Area 3: \_\_\_\_\_



16) **Have you been vaccinated for Hepatitis B?** (check one box only)

- 1 Yes, fully, 3 doses
- 2 Yes, partially, 1 or 2 doses
- 3 No
- 4 Not applicable

17) **Describe the circumstances leading to this exposure:**

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**Cost:**

\_\_\_\_\_ **Lab charges (Hb, HCV, HIV, other)**  
 \_\_\_\_\_ 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 government reportable?**  1 Yes  2 No  3 Unknown

If Yes, Days Away from Work? \_\_\_\_\_  
 Days of Restricted Work Activity? \_\_\_\_\_

**Does this incident meet the medical device reporting criteria?** (Yes if a device defect caused serious injury necessitating medical or surgical intervention, or death occurred within 10 work days of incident.)

- 1 Yes
- 2 No