Blood and Body Fluid Exposure Report

(Non-Sharps Exposures)

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. Home/Employing department/Cost center: ______________________________________________________

3a. Department where injury occurred (optional): ____________________________________________________

4. What is the job category of the exposed worker? (check one box only)
   □ 1 Doctor (attending/staff); specify specialty: ____________________________ □ 21 IV team
   □ 2 Doctor (intern/resident/fellow) specify specialty: ____________________________ □ 10 Clinical laboratory worker
   □ 22 Physician’s assistant: ____________________________ □ 11 Technologist (non-lab)
   □ 3 Medical student: ____________________________ □ 12 Dentist
   □ 4 Nurse: specify ____________________________ □ 1 R.N.
   □ 5 Nursing student: ____________________________ □ 2 L.P.N./L.V.N.
   □ 18 C.N.A./H.H.A.: ____________________________ □ 3 N.P.
   □ 6 Respiratory therapist: ____________________________ □ 4 C.R.N.A.
   □ 7 Surgery tech/attendant: ____________________________ □ 5 Midwife
   □ 8 Other attendant: ____________________________ □ 19 Laundry worker
   □ 9 Phlebotomist/Venipuncture: ____________________________ □ 20 Security
   □ 5. Where did the exposure occur? (check one box only)
     □ 1 Patient room: ____________________________ □ 9 Dialysis facility (hemodialysis and peritoneal dialysis)
     □ 2 Outside patient room (hallway, nurses station, etc.): ____________________________ □ 10 Procedure room (x-ray, EKG, etc)
     □ 3 Emergency department: ____________________________ □ 11 Clinical laboratories
     □ 4 Intensive/Critical care unit: specify type: ____________________________ □ 12 Autopsy/Pathology
     □ 5 Operating room/Recovery: ____________________________ □ 13 Service/Utility (laundry, central supply, sterile processing, waste, etc)
     □ 6 Outpatient clinic/Office: ____________________________ □ 16 Labor and delivery room
     □ 7 Blood bank: ____________________________ □ 17 Home-care
     □ 8 Venipuncture center: ____________________________ □ 14 Other, describe: ____________________________

6. Was the source patient identifiable? (check one box only)
   □ 1 Yes □ 2 No □ 3 Unknown □ 4 Not applicable

7. Which of the patient’s body fluids were involved in the exposure? (check all that apply)
   □ Blood or blood products
   □ Vomit
   □ Sputum
   □ Saliva
   □ CSF
   □ Other, describe: ____________________________

7a. Was the body fluid visibly contaminated with blood? □ 1 Yes □ 2 No □ 3 Unknown

8. Was the worker’s exposed part? (check all that apply)
   □ 1 Intact skin
   □ 2 Non-intact skin
   □ 3 Eyes (conjunctiva)
   □ Nose (mucosa)
   □ Mouth (mucosa)
   □ Other, describe: ____________________________

9. 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/uniform

9a. Did the exposure result in the need to remove a garment and obtain a replacement? □ 1 Yes □ 2 No

10. Which barrier garments and/or personal protective equipment were worn at the time of exposure? (check all that apply)
    □ Single pair latex/vinyl/nitrile gloves
    □ Respirator
    □ Double pair latex/vinyl/nitrile gloves
    □ Gowns: Surgical, isolation, chemotherapy
    □ Eyeglasses (not a protective item)
    □ Plastic apron
    □ Eyeglasses with side shields
    □ Lab coat/Scrub jacket (not protective garments)
    □ Protective eyewear/Goggles
    □ Scrubs/Uniform (not protective garments)
    □ Face shield
    □ Other specialized garment worn as protection
    □ Surgical mask
    □ Other, describe: ____________________________
11. Was the exposure the result of?  (check one box only)
   □ 1 During patient procedure, describe _________________________  □ 5 Other body fluid container spilled/leaked
   □ 11 Patient initiated (spitting/biting/vomiting etc.)  □ 6 Touched contaminated equipment/surface
   □ 2 Specimen container leaked/spilled  □ 7 Touched contaminated drapes/sheets/gowns, etc.
   □ 3 Specimen container broke  □ 8 Unknown
   □ 4 IV Tubing/Bag/Pump leaked/broke  □ 9 Other, describe: ____________________________
   □ 10 Feeding/Ventilator/Other tube separated/leaked/spashed
      Specify tubing: ____________________________

11a. Did the incident result in an exposure to a hazardous drug (e.g. chemotherapy, antineoplastic)?  □ 1. Yes  □ 2. No  □ 3. Unknown

11b. If equipment failure, please specify:
   Equipment type: ____________________________
   Manufacturer: ______________________________

12. For how long was the blood or body fluid In contact with your skin or mucous membranes?  (check one box only)
   □ 1 Less than 5 minutes
   □ 2 5-14 minutes
   □ 3 15 minutes to 1 hour
   □ 4 More than 1 hour
   □ 5 Unknown

13. How much blood/body fluid came in contact with your skin or mucous membranes?  (check one box only)
   □ 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)

14. Location of the exposure:

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

   Largest area of exposure: _____
   Middle area of exposure: _____
   Smallest area of exposure: _____

15. Employment status of injured worker:
   □ 1 Employee  □ 3 Student  □ 5 Non-employee/Practitioner
   □ 2 Temp/Contract  □ 4 Volunteer  □ 6 Other

16. Describe the circumstances leading to this exposure:  (please note if a device malfunction was involved):

   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

Is this incident OSHA recordable?  (for office use only)
   □ 1 Yes  □ 2 No  □ 3 Unknown
   If yes:
   Days away from work: _____
   Days of restricted work activity: _____

Was prophylaxis provided?  (for office use only)
   □ 1 Yes  □ 2 No  □ 3 Unknown

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.)  (for office use only)
   □ 1 Yes (If yes, follow FDA reporting protocol.)  □ 2 No  □ 3 Unknown

See following page to enter Cost data.

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<table>
<thead>
<tr>
<th>Cost: (optional, for office use only)</th>
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<tbody>
<tr>
<td>Lab charges (HBV, HCV, HIV, other)</td>
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<tr>
<td>Healthcare worker</td>
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<tr>
<td>Source</td>
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<tr>
<td>Treatment/Prophylaxis (HBIG, HBV vaccine, tetanus, other)</td>
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<tr>
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<td>Source</td>
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<tr>
<td>Service charges (Emergency Dept, Employee Health, other)</td>
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<tr>
<td>Other costs (Worker’s Comp, surgery, other)</td>
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<tr>
<td>Paid Time Off</td>
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<tr>
<td>TOTAL</td>
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