

UNIFORM BLOOD AND BODY FLUID EXPOSURE REPORT



Last Name: _____ First Name: _____

1. Injury ID: *for office use only* B _____ 1a. Facility ID: *for office use only* _____

2. Date of exposure: / / 2a. Time of exposure: : am pm

3. Department where exposure occurred: _____

4. Home Department: _____ 4a. Filled out by: _____

5) Job Category: (check one)

- | | |
|--|--|
| <input type="radio"/> 1 M.D. (<i>attending/staff</i>); specify specialty: _____ | <input type="radio"/> 10 clinical laboratory worker |
| <input type="radio"/> 2 M.D. (<i>intern/resident/fellow</i>); specify specialty: _____ | <input type="radio"/> 11 technologist (<i>non-lab</i>) |
| <input type="radio"/> 3 medical student | <input type="radio"/> 12 dentist |
| <input type="radio"/> 4 nurse: specify: <input type="checkbox"/> 1 RN | <input type="radio"/> 13 dental hygienist |
| <input type="radio"/> 5 nursing student <input type="checkbox"/> 2 LPN | <input type="radio"/> 14 housekeeper |
| <input type="radio"/> 18 CNA/HHA <input type="checkbox"/> 3 NP | <input type="radio"/> 19 laundry worker |
| <input type="radio"/> 6 respiratory therapist <input type="checkbox"/> 4 CRNA | <input type="radio"/> 20 security |
| <input type="radio"/> 7 surgery attendant <input type="checkbox"/> 5 midwife | <input type="radio"/> 16 paramedic |
| <input type="radio"/> 8 other attendant | <input type="radio"/> 17 other student |
| <input type="radio"/> 9 phlebotomist/venipuncture/L.V. team | <input type="radio"/> 15 other, describe: _____ |

6) Where did the exposure occur: (check one)

- | | |
|--|--|
| <input type="radio"/> 1 patient room | <input type="radio"/> 9 dialysis facility (<i>hemodialysis and peritoneal dialysis</i>) |
| <input type="radio"/> 2 outside patient room (<i>hallway, nurses' station, etc.</i>) | <input type="radio"/> 10 procedure room (<i>x-ray, EMG, etc.</i>) |
| <input type="radio"/> 3 emergency department | <input type="radio"/> 11 clinical laboratories |
| <input type="radio"/> 4 intensive/critical care unit: specify type: _____ | <input type="radio"/> 12 autopsy/pathology |
| <input type="radio"/> 5 operating room | <input type="radio"/> 13 service/utility area (<i>laundry, central supply, loading dock, etc.</i>) |
| <input type="radio"/> 6 outpatient clinic/office | <input type="radio"/> 16 labor and delivery room |
| <input type="radio"/> 7 blood bank | <input type="radio"/> 17 home care |
| <input type="radio"/> 8 venipuncture center | <input type="radio"/> 14 other, describe: _____ |

7) Was the source patient identifiable?: (check one)

- 1 yes 2 no 3 unknown 4 not applicable

8) Which body fluids were involved in the exposure? (check all that apply)

- | | |
|---|--|
| <input type="radio"/> blood or blood products | <input type="radio"/> peritoneal fluid |
| <input type="radio"/> vomit | <input type="radio"/> pleural fluid |
| <input type="radio"/> sputum | <input type="radio"/> amniotic fluid |
| <input type="radio"/> saliva | <input type="radio"/> urine |
| <input type="radio"/> CSF | <input type="radio"/> other, describe: _____ |

Was the body fluid other than blood visibly contaminated with blood? yes no

9) Was the exposed part: (check all that apply)

- | | |
|--|--|
| <input type="radio"/> intact skin | <input type="radio"/> nose (mucosa) |
| <input type="radio"/> non-intact skin | <input type="radio"/> mouth (mucosa) |
| <input type="radio"/> eyes (conjunctiva) | <input type="radio"/> other, describe: _____ |

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

- | | |
|---|--|
| <input type="radio"/> touch unprotected skin | <input type="radio"/> soak through protective garment or barrier |
| <input type="radio"/> touch skin between gap in protective garments | <input type="radio"/> soak through clothing |

11) Which protective items were worn at the time of the exposure?: (check all that apply)

- | | |
|--|--|
| <input type="radio"/> single pair latex/vinyl gloves | <input type="radio"/> surgical mask |
| <input type="radio"/> double pair latex/vinyl gloves | <input type="radio"/> surgical gown |
| <input type="radio"/> goggles | <input type="radio"/> plastic apron |
| <input type="radio"/> eyeglasses | <input type="radio"/> lab coat, cloth |
| <input type="radio"/> eyeglasses with sideshields | <input type="radio"/> lab coat, other |
| <input type="radio"/> faceshield | <input type="radio"/> other, describe: _____ |

12) Was the exposure the result of: (check one)

- 1 direct patient contact
- 2 specimen container leaked/spilled
- 3 specimen container broke
- 4 I.V. tubing/bag/pump leaked/broke
- 10 feeding/ventilator/other tube separated/leaked/splashed
specify tubing: _____

- 5 other body fluid container spilled/leaked
- 6 touched contaminated equipment/surface
- 7 touched contaminated drapes/sheets/gowns, etc.
- 8 unknown
- 9 other, describe: _____

If equipment failure, please specify: equipment type: _____
 manufacturer: _____

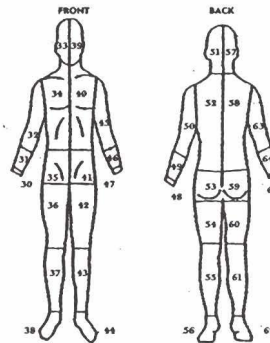
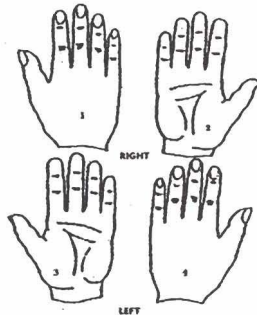
13) For how long was the blood or body fluid in contact with your skin or mucous membranes?

- 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 a teaspoon)
- 2 moderate amount (up to 50 cc, or up to a quarter cup)
- 3 large amount (more than 50 cc)

15) MARK THE SIZE AND LOCATION OF THE EXPOSURE:



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

17) For exposed employee: Do you have an opinion that any engineering, administrative or work practice could have prevented the exposure?

- yes
- no

Explain: _____

FOR OFFICE USE ONLY:

		lab charges (Hb, HCV, HIV, other)
		- Employee
		- Source
		Treatment/prophylaxis (HBIG, Hb vaccine, tetanus, other)
		- Employee
		- Source
		Service charges (Emerg. Dept., Empf. Health, other)
		Other costs (Workers' Comp., surgery, other)
		Total (round to nearest dollar)

In this incident OSHA reportable?

Medical treatment (HBIG, Hepatitis vaccine, gamma globulin, AZT, etc.; not first aid, not tetanus)

Restricted/lost work time; job transfer

• illness / death

Yes No

If yes, enter:

			days away from work
			days 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 work days of incident.)

Yes No

If yes, refer to EPINET manual for FDA reporting protocol.