



# 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 \_\_\_\_\_
- 2 Doctor (intern/resident/fellow) specify specialty \_\_\_\_\_
- 22 Physician's assistant
- 3 Medical student
- 4 Nurse: specify \_\_\_\_\_
- 5 Nursing student
- 18 C.N.A./H.H.A.
- 6 Respiratory therapist
- 7 Surgery tech/attendant
- 8 Other attendant
- 9 Phlebotomist/Venipuncture
- 1 R.N.
- 2 L.P.N./L.V.N.
- 3 N.P.
- 4 C.R.N.A.
- 5 Midwife
- 21 IV team
- 10 Clinical laboratory worker
- 11 Technologist (non-lab)
- 12 Dentist
- 13 Dental hygienist
- 14 EVS/Housekeeper
- 19 Laundry worker
- 20 Security
- 16 EMT/Paramedic/First Responder
- 17 Other student
- 15 Other, describe: \_\_\_\_\_

5. Where did the exposure occur? (check one box only)

- 1 Patient room
- 2 Outside patient room (hallway, nurses station, etc.)
- 3 Emergency department
- 4 Intensive/Critical care unit: specify type: \_\_\_\_\_
- 5 Operating room/Recovery
- 6 Outpatient clinic/Office
- 7 Blood bank
- 8 Venipuncture center
- 9 Dialysis facility (hemodialysis and peritoneal dialysis)
- 10 Procedure room (x-ray, EKG, etc)
- 11 Clinical laboratories
- 12 Autopsy/Pathology
- 13 Service/Utility (laundry, central supply, sterile processing, waste, etc)
- 16 Labor and delivery room
- 17 Home-care
- 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
- Peritoneal fluid
- Pleural fluid
- Amniotic fluid
- Urine
- 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)

- Intact skin
- Non-intact skin
- 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
- Double pair latex/vinyl/nitrile gloves
- Eyeglasses (not a protective item)
- Eyeglasses with side shields
- Protective eyewear/Goggles
- Face shield
- Surgical mask
- Respirator
- Gowns: Surgical, isolation, chemotherapy
- Plastic apron
- Lab coat/Scrub jacket (not protective garments)
- Scrubs/Uniform (not protective garments)
- Other specialized garment worn as protection
- Other, describe: \_\_\_\_\_

**11. Was the exposure the result of?** (check one box only)

- |  |   |
|--|---|
| <input type="checkbox"/> 1 During patient procedure, describe _____  | <input type="checkbox"/> 5 Other body fluid container spilled/leaked      |
| <input type="checkbox"/> 11 Patient initiated (spitting/biting/vomiting etc.)                                | <input type="checkbox"/> 6 Touched contaminated equipment/surface         |
| <input type="checkbox"/> 2 Specimen container leaked/spilled   | <input type="checkbox"/> 7 Touched contaminated drapes/sheets/gowns, etc. |
| <input type="checkbox"/> 3 Specimen container broke  | <input type="checkbox"/> 8 Unknown  |
| <input type="checkbox"/> 4 IV Tubing/Bag/Pump leaked/broke   | <input type="checkbox"/> 9 Other, describe: _____                         |
| <input type="checkbox"/> 10 Feeding/Ventilator/Other tube separated/leaked/splashed<br>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)

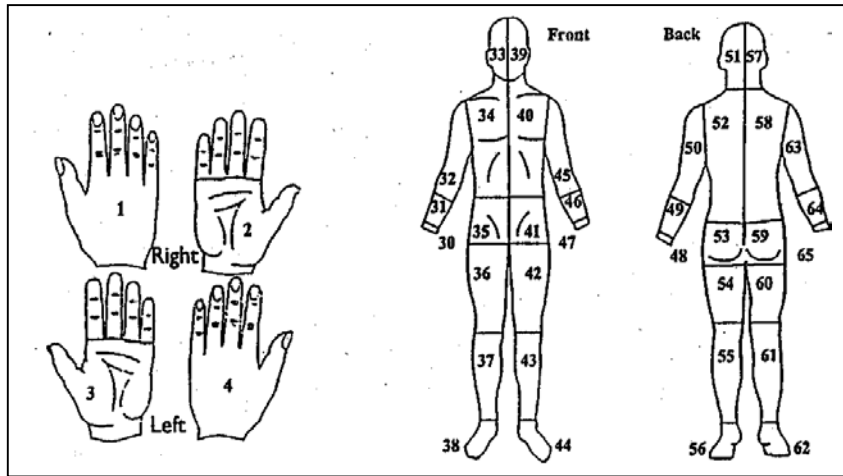
**14. Location of the exposure:**

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:**

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> 1 Employee      | <input type="checkbox"/> 3 Student   | <input type="checkbox"/> 5 Non-employee/Practitioner |
| <input type="checkbox"/> 2 Temp/Contract | <input type="checkbox"/> 4 Volunteer | <input type="checkbox"/> 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.

Cost: (optional, for office use only)

_____	Lab charges (HBV, HCV, HIV, other)
_____	Healthcare worker
_____	Source
_____	Treatment/Prophylaxis (HBIG, HBV vaccine, tetanus, other)
_____	Healthcare worker
_____	Source
_____	Service charges (Emergency Dept, Employee Health, other)
_____	Other costs (Worker's Comp, surgery, other)
_____	Paid Time Off
_____	TOTAL