

\*required for saving

Facility ID#: \_\_\_\_\_ Exposure Event# \_\_\_\_\_

\*HCW ID#: \_\_\_\_\_

HCW Name, Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

\*Gender:  F  M  Other \*Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

\*Work Location: \_\_\_\_\_

\*Occupation \_\_\_\_\_ If occupation is physician, indicate clinical specialty \_\_\_\_\_

**Section I - General Exposure Information**1. \*Did exposure occur in this facility:  Y  N  
1a. If No, specify name of facility in which exposure occurred: \_\_\_\_\_2. \*Date of exposure: \_\_\_/\_\_\_/\_\_\_\_\_ 3. \*Time of exposure: \_\_\_\_\_  AM  PM4. Number of hours on duty: \_\_\_\_\_ 5. Is exposed person a temp/agency employee?  Y  N

6. \*Location where exposure occurred: \_\_\_\_\_

7. \*Type of exposure: (Check all that apply)
- 7a. Percutaneous: Did exposure involve a clean, unused needle or sharp object?  
 Y  N (If No, complete Q8, Q9, Section II and Section V-XI)
  - 7b. Mucous membrane (Complete Q8, Q9, Section III and Section V-XI)
  - 7c. Skin: Was skin intact?  Y  N  Unknown (If No, complete Q8, Q9, Section III & Section V-XI)
  - 7d. Bite (Complete Q9, and Section IV-XI)

8. \* Type of fluid/tissue involved in exposure: (Check one)
- |  |   |
|--|---|
| <input type="checkbox"/> Blood/blood products                                | <input type="checkbox"/> Body fluids: (Check one) |
| <input type="checkbox"/> Solutions (IV fluid, irrigation, etc.): (Check one) | <input type="checkbox"/> Visibly bloody           |
| <input type="checkbox"/> Visibly bloody                                      | <input type="checkbox"/> Not visibly bloody       |
| <input type="checkbox"/> Not visibly bloody                                  |   |
| <input type="checkbox"/> Tissue  |   |
| <input type="checkbox"/> Other (specify) _____                               |   |
| <input type="checkbox"/> Unknown   |   |

- If body fluid, indicate one body fluid type:
- |  |  |
|--|--|
| <input type="checkbox"/> Amniotic      | <input type="checkbox"/> Saliva                |
| <input type="checkbox"/> CSF           | <input type="checkbox"/> Sputum                |
| <input type="checkbox"/> Pericardial   | <input type="checkbox"/> Tears                 |
| <input type="checkbox"/> Peritoneal    | <input type="checkbox"/> Urine                 |
| <input type="checkbox"/> Pleural       | <input type="checkbox"/> Feces/stool           |
| <input type="checkbox"/> Semen         | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Synovial      | _____  |
| <input type="checkbox"/> Vaginal fluid |  |

9. \*Body site of exposure: (Check all that apply)
- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Hand/finger | <input type="checkbox"/> Foot                  |
| <input type="checkbox"/> Eye         | <input type="checkbox"/> Mouth                 |
| <input type="checkbox"/> Arm         | <input type="checkbox"/> Nose                  |
| <input type="checkbox"/> Leg         | <input type="checkbox"/> Other (specify) _____ |

**Assurance of Confidentiality:** The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

## Section II - Percutaneous Injury

1. \*Was the needle or sharp object visibly contaminated with blood prior to exposure?  Y  N

2. Depth of the injury: (Check one)

- |   |   |
|---|---|
| <input type="checkbox"/> Superficial, surface scratch | <input type="checkbox"/> Deep puncture or wound |
| <input type="checkbox"/> Moderate, penetrated skin    | <input type="checkbox"/> Unknown                |

3. What needle or sharp object caused the injury? (Check one)

- Device (select one)  Non-device sharp object (specify) \_\_\_\_\_  Unknown sharp object

*Hollow-bore needle*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arterial blood collection device       | <input type="checkbox"/> Biopsy needle                            | <input type="checkbox"/> Bone marrow needle           |
| <input type="checkbox"/> Hypodermic needle, attached to syringe | <input type="checkbox"/> Hypodermic needle, attached to IV tubing | <input type="checkbox"/> Unattached hypodermic needle |
| <input type="checkbox"/> IV catheter - central line             | <input type="checkbox"/> IV catheter - peripheral line            | <input type="checkbox"/> Huber needle                 |
| <input type="checkbox"/> Prefilled cartridge syringe            | <input type="checkbox"/> IV stylet                                | <input type="checkbox"/> Spinal or epidural needle    |
| <input type="checkbox"/> Hemodialysis needle                    | <input type="checkbox"/> Dental aspirating syringe w/ needle      | <input type="checkbox"/> Vacuum tube holder/needle    |
| <input type="checkbox"/> Winged-steel (Butterfly™ type) needle  | <input type="checkbox"/> Hollow-bore needle, type unknown         | <input type="checkbox"/> Other hollow-bore needle     |

*Suture needle*

- Suture needle

*Other solid sharps*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bone cutter      | <input type="checkbox"/> Bur            | <input type="checkbox"/> Electrocautery device |
| <input type="checkbox"/> Elevator         | <input type="checkbox"/> Explorer       | <input type="checkbox"/> Extraction forceps    |
| <input type="checkbox"/> File             | <input type="checkbox"/> Lancet         | <input type="checkbox"/> Microtome blade       |
| <input type="checkbox"/> Pin              | <input type="checkbox"/> Razor          | <input type="checkbox"/> Retractor             |
| <input type="checkbox"/> Rod (orthopedic) | <input type="checkbox"/> Scaler/curette | <input type="checkbox"/> Scalpel blade         |
| <input type="checkbox"/> Scissors         | <input type="checkbox"/> Tenaculum      | <input type="checkbox"/> Trocar                |
| <input type="checkbox"/> Wire             |   |  |

*Glass*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Capillary tube | <input type="checkbox"/> Blood collection tube | <input type="checkbox"/> Medication ampule/vial/bottle |
| <input type="checkbox"/> Pipette        | <input type="checkbox"/> Slide                 | <input type="checkbox"/> Specimen/test/vacuum tube     |

*Plastic*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Capillary tube | <input type="checkbox"/> Blood collection tube | <input type="checkbox"/> Specimen/test/vacuum tube |
|---|--|--|

*Non-sharp safety device*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Blood culture adapter              | <input type="checkbox"/> Catheter securement device | <input type="checkbox"/> IV delivery system |
| <input type="checkbox"/> Other known device (specify) _____ |   |   |

4. Manufacturer and Model: \_\_\_\_\_

5. Did the needle or other sharp object involved in the injury have a safety feature?  Y  N

5a. If yes, indicate type of safety feature: (Check one) If No, skip to Q6.

- |   |   |
|---|---|
| <input type="checkbox"/> Bluntable needle, sharp      | <input type="checkbox"/> Needle/sharp ejector                 |
| <input type="checkbox"/> Hinged guard/shield          | <input type="checkbox"/> Mylar wrapping/plastic               |
| <input type="checkbox"/> Retractable needle/sharp     | <input type="checkbox"/> Other safety feature (specify) _____ |
| <input type="checkbox"/> Sliding/gliding guard/shield | <input type="checkbox"/> Unknown safety mechanism             |

5b. If the device had a safety feature, when did the injury occur? (Check one)

- |  |  |
|--|--|
| <input type="checkbox"/> Before activation of the safety feature was appropriate | <input type="checkbox"/> Safety feature failed, after activation |
| <input type="checkbox"/> During activation of the safety feature                 | <input type="checkbox"/> Safety feature not activated            |
| <input type="checkbox"/> Safety feature improperly activated                     | <input type="checkbox"/> Other (specify) _____                   |

6. When did the injury occur? (check one)

- |  |   |
|--|---|
| <input type="checkbox"/> Before use of the item                | <input type="checkbox"/> During or after disposal |
| <input type="checkbox"/> During use of the item                | <input type="checkbox"/> Unknown                  |
| <input type="checkbox"/> After use of the item before disposal |   |

7. For what purpose or activity was the sharp device being used: (Check one)

*Obtaining a blood specimen percutaneously*

- |   |   |
|---|---|
| <input type="checkbox"/> Performing phlebotomy        | <input type="checkbox"/> Performing a fingerstick/heelstick             |
| <input type="checkbox"/> Performing arterial puncture | <input type="checkbox"/> Other blood-sampling procedure (specify) _____ |

*Giving a percutaneous injection*

- |   |  |
|---|--|
| <input type="checkbox"/> Giving an IM injection | <input type="checkbox"/> Placing a skin test (e.g., tuberculin, allergy, etc.) |
| <input type="checkbox"/> Giving a SC injection  |  |

*Performing a line related procedure*

- |  |  |
|--|--|
| <input type="checkbox"/> Inserting or withdrawing a catheter                                     | <input type="checkbox"/> Injecting into a line or port |
| <input type="checkbox"/> Obtaining a blood sample from a central or peripheral I.V. line or port | <input type="checkbox"/> Connecting an I.V. line       |

*Performing surgery/autopsy/other invasive procedure*

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Suturing | <input type="checkbox"/> Palpating/exploring |
| <input type="checkbox"/> Incising | Specify procedure: _____                     |

*Performing a dental procedure*

- |   |  |
|---|--|
| <input type="checkbox"/> Hygiene (prophylaxis)                  | <input type="checkbox"/> Oral surgery        |
| <input type="checkbox"/> Restoration (amalgam composite, crown) | <input type="checkbox"/> Simple extraction   |
| <input type="checkbox"/> Root canal                             | <input type="checkbox"/> Surgical extraction |
| <input type="checkbox"/> Periodontal surgery                    |  |

*Handling a specimen*

- |   |  |
|---|--|
| <input type="checkbox"/> Transferring BBF into a specimen container | <input type="checkbox"/> Processing specimen |
|---|--|

*Other*

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Other diagnostic procedure (e.g., thoracentesis) | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other (specify) _____                            |                                  |

8. What was the activity at the time of injury? (Check one)

- |  |  |
|--|--|
| <input type="checkbox"/> Cleaning room                             | <input type="checkbox"/> Collecting/transporting waste                   |
| <input type="checkbox"/> Decontamination/processing used equipment | <input type="checkbox"/> Disassembling device/equipment                  |
| <input type="checkbox"/> Handling equipment                        | <input type="checkbox"/> Opening/breaking glass container (e.g., ampule) |
| <input type="checkbox"/> Performing procedure                      | <input type="checkbox"/> Placing sharp in container                      |
| <input type="checkbox"/> Recapping                                 | <input type="checkbox"/> Transferring/passing/receiving device           |
| <input type="checkbox"/> Other (specify) _____                     |  |

9. Who was holding the device at the time the injury occurred? (Check one)

- |   |   |
|---|---|
| <input type="checkbox"/> Exposed person         | <input type="checkbox"/> No one, the sharp was an uncontrolled sharp in the environment |
| <input type="checkbox"/> Co-worker/other person |   |

10. What happened when the injury occurred? (Check one)

- |  |   |
|--|---|
| <input type="checkbox"/> Patient moved and jarred device         | <input type="checkbox"/> Contact with overfilled/punctured sharps container |
| <input type="checkbox"/> Device slipped                          | <input type="checkbox"/> Improperly disposed sharp                          |
| <input type="checkbox"/> Device rebounded                        | <input type="checkbox"/> Other (specify) _____                              |
| <input type="checkbox"/> Sharp was being recapped                | <input type="checkbox"/> Unknown  |
| <input type="checkbox"/> Collided with co-worker or other person |   |

## Section III - Mucous Membrane and/or Skin Exposure

1. Estimate the amount of blood/body fluid exposure: (Check one)

- |   |   |
|---|---|
| <input type="checkbox"/> Small (<1 tsp or 5cc)                        | <input type="checkbox"/> Large (>¼ cup or 50cc) |
| <input type="checkbox"/> Moderate (>1 tsp and up to ¼ cup, or 6-50cc) | <input type="checkbox"/> Unknown                |

2. Activity/event when exposure occurred: (Check one)

- |   |  |
|---|--|
| <input type="checkbox"/> Airway manipulation (e.g., suctioning airway, inducing sputum) | <input type="checkbox"/> Patient spit/coughed/vomited  |
| <input type="checkbox"/> Bleeding vessel  | <input type="checkbox"/> Phlebotomy  |
| <input type="checkbox"/> Changing dressing/wound care                                   | <input type="checkbox"/> Surgical procedure (e.g., all surgical procedures including C-section)                      |
| <input type="checkbox"/> Cleaning/transporting contaminated equipment                   | <input type="checkbox"/> Tube placement/removal/manipulation (e.g., chest, endotracheal, NG, rectal, urine catheter) |
| <input type="checkbox"/> Endoscopic procedures  | <input type="checkbox"/> Vaginal delivery  |
| <input type="checkbox"/> IV or arterial line insertion/removal/manipulation             | <input type="checkbox"/> Other (specify) _____   |
| <input type="checkbox"/> Irrigation procedures  | <input type="checkbox"/> Unknown   |
| <input type="checkbox"/> Manipulating blood tube/bottle/specimen container              |  |

3. Barriers used by the worker at the time of exposure: (Check all that apply)

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Face shield | <input type="checkbox"/> Mask/respirator       |
| <input type="checkbox"/> Gloves      | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Goggles     | <input type="checkbox"/> No Barriers           |
| <input type="checkbox"/> Gown        |  |

## Section IV - Bite

1. Wound description: (Check one)

- |  |   |
|--|---|
| <input type="checkbox"/> No spontaneous bleeding | <input type="checkbox"/> Tissue avulsed |
| <input type="checkbox"/> Spontaneous bleeding    | <input type="checkbox"/> Unknown        |

2. Activity/event when exposure occurred: (Check one)

- |   |  |
|---|--|
| <input type="checkbox"/> During dental procedure            | <input type="checkbox"/> Assault by patient    |
| <input type="checkbox"/> During oral examination            | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Providing oral hygiene             | <input type="checkbox"/> Unknown               |
| <input type="checkbox"/> Providing non-oral care to patient |  |



**Section VIII - Baseline Lab Testing**

Was baseline testing performed on the HCW?  Y  N  U    If Yes, indicate results

Test	Date	Result				Test	Date	Result
		P	N	I	R			
HIV EIA	__/__/__	P	N	I	R	ALT	__/__/__	__ IU/L
HIV Confirmatory	__/__/__	P	N	I	R	Amylase	__/__/__	__ IU/L
Hepatitis C anti-HCV-EIA	__/__/__	P	N	I	R	Blood glucose	__/__/__	__ mmol/L
Hepatitis C anti-HCV-supp	__/__/__	P	N	I	R	Hematocrit	__/__/__	__ %
Hepatitis C PCR HCV RNA	__/__/__	P	N	R		Hemoglobin	__/__/__	__ gm/L
Hepatitis B HBs Ag	__/__/__	P	N	R		Platelets	__/__/__	__ x10 <sup>9</sup> /L
Hepatitis B IgM anti-HBc	__/__/__	P	N	R		Blood cells in Urine	__/__/__	__ #/mm <sup>3</sup>
Hepatitis B Total anti-HBc	__/__/__	P	N	R		WBC	__/__/__	__ x10 <sup>9</sup> /L
Hepatitis B Anti-HBs	__/__/__	__ mIU/mL				Creatinine	__/__/__	__ μmol/L
Result Codes: P=Positive, N=Negative, I=Indeterminate, R=Refused						Other:	__/__/__	__

**Section IX - Follow-up**

1. Is it recommended that the HCW return for follow-up of this exposure?  Y  N
  - 1a. If yes, will follow-up be performed at this facility?  Y  N

**Section X - Narrative**

In the worker's words, how did the injury occur?

**Section XI - Prevention**

In the worker's words, what could have prevented the injury?

**Custom Fields**

Label	Label
_____ __/__/__	_____ __/__/__
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Comments**