Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Exposure to Blood/Body Fluids

*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 ☐ PM

4. 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)

   ☐ Blood/blood products
   ☐ Solutions (IV fluid, irrigation, etc.): (Check one)
   - ☐ Visibly bloody
   - ☐ Not visibly bloody

   ☐ Tissue
   ☐ Other (specify): _________________________
   ☐ Unknown

   ☐ Body fluids: (Check one)
   - ☐ Visibly bloody
   - ☐ Not visibly bloody

   If body fluid, indicate one body fluid type:

   ☐ Amniotic ☐ Saliva
   ☐ CSF ☐ Sputum
   ☐ Pericardial ☐ Tears
   ☐ Peritoneal ☐ Urine
   ☐ Pleural ☐ Feces/stool
   ☐ Semen ☐ Other (Specify): _____________________
   ☐ Synovial
   ☐ Vaginal fluid

9. *Body site of exposure: (Check all that apply)

   ☐ Hand/finger ☐ Foot
   ☐ Eye ☐ Mouth
   ☐ Arm ☐ Nose
   ☐ Leg ☐ 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).

Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Exposure to Blood/Body Fluids

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)

☐ Superficial, surface scratch ☐ Deep puncture or wound
☐ Moderate, penetrated skin ☐ 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

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

Suture needle

☐ Suture needle

Other solid sharps

☐ Bone cutter ☐ Bur ☐ Electrocautery device
☐ Elevator ☐ Explorer ☐ Extraction forceps
☐ File ☐ Lancet ☐ Microtome blade
☐ Pin ☐ Razor ☐ Retractor
☐ Rod (orthopedic) ☐ Scaler/curette ☐ Scalpel blade
☐ Scissors ☐ Tenaculum ☐ Trocar
☐ Wire

Glass

☐ Capillary tube ☐ Blood collection tube ☐ Medication ampule/vial/bottle
☐ Pipette ☐ Slide ☐ Specimen/test/vacuum tube

Plastic

☐ Capillary tube ☐ Blood collection tube ☐ Specimen/test/vacuum tube

Non-sharp safety device

☐ Blood culture adapter ☐ Catheter securement device ☐ IV delivery system
☐ Other known device (specify): _________________________________

4. Manufacturer and Model: _____________________________________

Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Exposure to Blood/Body Fluids

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.

- ☐ Bluntable needle, sharp
- ☐ Hinged guard/shield
- ☐ Retractable needle/sharp
- ☐ Sliding/gliding guard/shield
- ☐ Needle/sharp ejector
- ☐ Mylar wrapping/plastic
- ☐ Other safety feature (specify):_____________________
- ☐ Unknown safety mechanism

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

- ☐ Before activation of the safety feature was appropriate
- ☐ During activation of the safety feature
- ☐ Safety feature improperly activated
- ☐ Safety feature failed, after activation
- ☐ Safety feature not activated
- ☐ Other (specify): ________________________________

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

- ☐ Before use of the item
- ☐ During use of the item
- ☐ After use of the item before disposal
- ☐ During or after disposal
- ☐ Unknown

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

Obtaining a blood specimen percutaneously

- ☐ Performing phlebotomy
- ☐ Performing arterial puncture
- ☐ Performing a fingerstick/heelstick
- ☐ Other blood-sampling procedure (specify): _______________________________________

Giving a percutaneous injection

- ☐ Giving an IM injection
- ☐ Giving a SC injection
- ☐ Placing a skin test (e.g., tuberculin, allergy, etc.)

Performing a line related procedure

- ☐ Inserting or withdrawing a catheter
- ☐ Obtaining a blood sample from a central or peripheral I.V. line or port
- ☐ Injecting into a line or port
- ☐ Connecting an I.V. line

Performing surgery/autopsy/other invasive procedure

- ☐ Suturing
- ☐ Incising
- ☐ Palpating/exploring
- ☐ Specify procedure: _______________________________

Performing a dental procedure

- ☐ Hygiene (prophylaxis)
- ☐ Restoration (amalgam composite, crown)
- ☐ Root canal
- ☐ Periodontal surgery
- ☐ Oral surgery
- ☐ Simple extraction
- ☐ Surgical extraction

Handling a specimen

- ☐ Transferring BBF into a specimen container
- ☐ Processing specimen

Other

- ☐ Other diagnostic procedure (e.g., thoracentesis)
- ☐ Other (specify): _______________________________
- ☐ Unknown

Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Exposure to Blood/Body Fluids

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

- ☐ Cleaning room
- ☐ Collecting/transporting waste
- ☐ Decontamination/processing used equipment
- ☐ Disassembling device/equipment
- ☐ Handling equipment
- ☐ Opening/breaking glass container (e.g., ampule)
- ☐ Performing procedure
- ☐ Placing sharp in container
- ☐ Recapping
- ☐ Transferring/passing/receiving device
- ☐ Other (specify): ____________________________________

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

- ☐ Exposed person
- ☐ Co-worker/other person
- ☐ No one, the sharp was an uncontrolled sharp in the environment

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

- ☐ Patient moved and jarred device
- ☐ Contact with overfilled/punctured sharps container
- ☐ Device slipped
- ☐ Improperly disposed sharp
- ☐ Device rebounded
- ☐ Other (specify): ______________________________
- ☐ Sharp was being recapped
- ☐ Unknown
- ☐ Collided with co-worker or other person

Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Exposure to Blood/Body Fluids

Section III – Mucous Membrane and/or Skin Exposure

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

☐ Small (<1 tsp or 5cc)
☐ Moderate (>1 tsp and up to ¼ cup, or 6-50 cc)
☐ Large (> ¼ cup or 50cc)
☐ Unknown

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

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

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

☐ Face shield
☐ Gloves
☐ Goggles
☐ Gown
☐ Mask/respirator
☐ Other (specify): ________________________________
☐ No barriers

Section IV – Bite

1. Wound description: (Check one)

☐ No spontaneous bleeding
☐ Spontaneous bleeding
☐ Tissue avulsed
☐ Unknown

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

☐ During dental procedure
☐ During oral examination
☐ Providing oral hygiene
☐ Providing non-oral care to patient
☐ Assault by patient
☐ Other (specify): ________________________________
☐ Unknown

Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Exposure to Blood/Body Fluids

Note: Section V-IX are required when following the protocols for Exposure Management.

Section V – Source Information

1. Was the source patient known? ☐ Y ☐ N

2. Was HIV status known at the time of exposure? ☐ Y ☐N

3. Check the test results for the source patient (P=positive, N=negative, I=indeterminate, U=unknown, R=refused, NT=not tested)

Hepatitis B	**P**	**N**	**I**	**U**	**R**	**NT**
HBsAg						
HBeAg						
Total anti-HBc						
Anti-HBs						
Hepatitis C						
Anti-HCV EIA						
Anti-HCV supplemental						
PCR-HCV RNA						
HIV						
EIA, ELISA						
Rapid HIV						
Confirmatory test						

Section VI – For HIV Infected Source

1. Stage of disease: (Check one)

☐ End-stage AIDS ☐ Other symptomatic HIV, not AIDS
☐ AIDS ☐ HIV infection, no symptoms
☐ Acute HIV illness ☐ Unknown

2. Is the source patient taking anti-retroviral drugs? ☐ Y ☐ N ☐ U

2a. If yes, indicate drug(s): ___________ ___________ ___________ ___________ ___________ ___________

3. Most recent CD4 count: ________mm^3 Date: ____ /______ (mo/yr)

4. Viral load: _____ copies/ml _____ undetectable Date: ____ /______ (mo/yr)

Section VII – Initial Care Given to Healthcare Worker

1. HIV postexposure prophylaxis:

Offered? ☐ Y ☐ N ☐ U Taken: ☐ Y ☐ N ☐ U (If Yes, complete PEP form)

2. HBIG given? ☐ Y ☐ N ☐ U Date administered: ____ /____ /_______

3. Hepatitis B vaccine given: ☐ Y ☐ N ☐ U Date 1st dose administered: ____ /____ /_______

4. Is the HCW pregnant? ☐ Y ☐ N ☐ U

4a. If yes, which trimester? ☐ 1 ☐ 2 ☐ 3 ☐ U

NHSN National Healthcare Safety Network

Exposure to Blood/Body Fluids

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
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 PRC HCV RNA	__ /__ /____	P	N	I		Hemoglobin	__ /__ /____	____ gm/L
Hepatitis B HBs Ag	__ /__ /____	P	N	I		Platelets	__ /__ /____	____ $x10^9/L$
Hepatitis B IgM anti-HBc	__ /__ /____	P	N	I		Blood cells in Urine	__ /__ /____	____ $\#/mm^3$
Hepatitis B Total anti-HBc	__ /__ /____	P	N	I		WBC	__ /__ /____	____ $x10^9/L$
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