



# Exposure to Blood/Body Fluids

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\*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)

<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	If body fluid, indicate one body fluid type:
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Amniotic <input type="checkbox"/> Saliva
<input type="checkbox"/> Unknown	<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): _____

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### 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: \_\_\_\_\_

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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 | <input type="checkbox"/> 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): _____                           |                                  |

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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)

- 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)

- |  |   |
|--|---|
| <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 |   |

## Exposure to Blood/Body Fluids

### 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 6-50 cc) | <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 |   |

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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)
 

<input type="checkbox"/> End-stage AIDS	<input type="checkbox"/> Other symptomatic HIV, not AIDS
<input type="checkbox"/> AIDS	<input type="checkbox"/> HIV infection, no symptoms
<input type="checkbox"/> Acute HIV illness	<input type="checkbox"/> 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<sup>3</sup>      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? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Taken: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U (If Yes, complete PEP form)
---	---
2. HBIG given?  Y  N  U      Date administered: \_\_\_ / \_\_\_ / \_\_\_
3. Hepatitis B vaccine given:  Y  N  U      Date 1<sup>st</sup> dose administered: \_\_\_ / \_\_\_ / \_\_\_
4. Is the HCW pregnant?  Y  N  U
  - 4a. If yes, which trimester?  1  2  3  U

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Section VIII – Baseline Lab Testing											
Was baseline testing performed on the HCW? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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 <sup>9</sup> /L			
Hepatitis B IgM anti-HBc	__/__/__	P	N	I		Blood cells in Urine	__/__/__	___ #/mm <sup>3</sup>			
Hepatitis B Total anti-HBc	__/__/__	P	N	I		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? <input type="checkbox"/> Y <input type="checkbox"/> N											
1a. If Yes, will follow-up be performed at this facility? <input type="checkbox"/> Y <input type="checkbox"/> 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											