



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 | |

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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: _____ mm³ 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 1st 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 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? <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										