

# Blood and Body Fluid Exposure Report

# EPINet™

**FOR MICROSOFT® ACCESS**  
**EXPOSURE PREVENTION**  
**INFORMATION NETWORK▶**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Incident ID: (office use only) \_\_\_\_\_ Facility ID: (office use only) \_\_\_\_\_ Birthdate: \_\_\_\_\_

1) Date of injury: \_\_\_\_\_ 2) Date reported: \_\_\_\_\_

3) Department where incident occurred: \_\_\_\_\_

4) Home/employing department: \_\_\_\_\_ Time of incident: \_\_\_\_\_

5) Healthcare worker job category: (tick one box only)

- |  |  |
|--|--|
| <input type="checkbox"/> 1 Doctor (VMO/HMO) specify specialty _____                | <input type="checkbox"/> 10 Laboratory/pathology staff |
| <input type="checkbox"/> 2 Doctor (MO/intern/resident) specify specialty _____     | <input type="checkbox"/> 11 Technologist (non-lab)     |
| <input type="checkbox"/> 3 Medical student   | <input type="checkbox"/> 12 Dentist                    |
| <input type="checkbox"/> 4 Nurse: specify $\implies$ <input type="checkbox"/> 1 RN | <input type="checkbox"/> 13 Dental therapist/nurse     |
| <input type="checkbox"/> 5 Nursing student <input type="checkbox"/> 2 EN           | <input type="checkbox"/> 21 CSSD/TSSU staff            |
| <input type="checkbox"/> 18 Nursing assistant                                      | <input type="checkbox"/> 14 Housekeeping               |
| <input type="checkbox"/> 24 Midwife  | <input type="checkbox"/> 19 Laundry worker             |
| <input type="checkbox"/> 22 Community health staff/allied health staff             | <input type="checkbox"/> 16 Ambulance staff/paramedic  |
| <input type="checkbox"/> 8 Orderly/ward/trolley person                             | <input type="checkbox"/> 17 Other student              |
| <input type="checkbox"/> 9 Blood collector   |  |
| <input type="checkbox"/> 23 Anaesthetic/perfusion tech                             | <input type="checkbox"/> 15 Other, specify: _____      |

6) Where did the injury occur? (tick one box only)

- |   |  |
|---|--|
| <input type="checkbox"/> 1 Ward/nursery/patient's room                          | <input type="checkbox"/> 9 Dialysis facility (haemodialysis and peritoneal dialysis)               |
| <input type="checkbox"/> 19 Dental cubicle                                      | <input type="checkbox"/> 10 Procedure areas (imaging, angiography, cardiac cath, etc)              |
| <input type="checkbox"/> 2 Outside patient room (hallway, nurses station, etc.) | <input type="checkbox"/> 11 Pathology/clinical laboratories  |
| <input type="checkbox"/> 3 Emergency department                                 | <input type="checkbox"/> 12 Autopsy  |
| <input type="checkbox"/> 4 Intensive/critical care: specify type: _____         | <input type="checkbox"/> 13 Nonclinical-service/utility (CSSD, laundry, supply, loading dock, etc) |
| <input type="checkbox"/> 5 Operating room/anaesthetic/cleanup/theatre/recovery  | <input type="checkbox"/> 16 Delivery/labour ward   |
| <input type="checkbox"/> 6 Community clinic/outpatient clinic                   | <input type="checkbox"/> 17 Patient's home   |
| <input type="checkbox"/> 8 Blood collection room                                | <input type="checkbox"/> 14 Other, specify: _____  |

7) Was the source patient identifiable? (tick one box only)

- 1 Yes  2 No  3 Unknown  4 Not applicable

8) To which body fluids was the healthcare worker exposed? (tick all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Blood or blood products | <input type="checkbox"/> CSF              | <input type="checkbox"/> Urine                 |
| <input type="checkbox"/> Vomit                   | <input type="checkbox"/> Peritoneal fluid |  |
| <input type="checkbox"/> Sputum                  | <input type="checkbox"/> Pleural fluid    | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Saliva                  | <input type="checkbox"/> Amniotic fluid   | (includes semen, breastmilk, etc.)             |

Was the body fluid visibly stained with blood?  1 Yes  2 No  3 Unknown

9) Which body surfaces of the healthcare worker were involved? (tick all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Intact skin        | <input type="checkbox"/> Nose (mucosa)         |
| <input type="checkbox"/> Non-intact skin    | <input type="checkbox"/> Mouth (mucosa)        |
| <input type="checkbox"/> Eyes (conjunctiva) | <input type="checkbox"/> Other, specify: _____ |

10) Did the blood or body fluid: (tick all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Touch unprotected skin                        | <input type="checkbox"/> Soak through barrier garment or protective garment |
| <input type="checkbox"/> Touch skin between gap in protective garments | <input type="checkbox"/> Soak through clothing                              |

11) Which barrier garments were worn at the time of exposure? (tick all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Gloves, single pair                | <input type="checkbox"/> Surgical mask                                   |
| <input type="checkbox"/> Gloves, double pair                | <input type="checkbox"/> Surgical gown                                   |
| <input type="checkbox"/> Goggles                            | <input type="checkbox"/> Plastic apron                                   |
| <input type="checkbox"/> Eyeglasses (not a protective item) | <input type="checkbox"/> Lab coat/gown, cloth (permeable-not protective) |
| <input type="checkbox"/> Eyeglasses with side shields       | <input type="checkbox"/> Lab coat/gown, other                            |
| <input type="checkbox"/> Face shield                        | <input type="checkbox"/> Other, specify: _____                           |

12) What was the exposure the result of? (tick one box only)

- |   |   |
|---|---|
| <input type="checkbox"/> 1 Direct patient contact                                   | <input type="checkbox"/> 5 Other body fluid container spilled/leaked      |
| <input type="checkbox"/> 2 Specimen container leaked/spilled                        | <input type="checkbox"/> 6 Touched contaminated equipment/surface         |
| <input type="checkbox"/> 3 Specimen container broke                                 | <input type="checkbox"/> 7 Touched contaminated drapes/sheets/gowns, etc. |
| <input type="checkbox"/> 4 IV tubing/bag/pump leaked/broke                          | <input type="checkbox"/> 8 Unknown  |
| <input type="checkbox"/> 10 Feeding/ventilator/other tube separated/leaked/splashed | <input type="checkbox"/> 11 Assault or non percutaneous bite              |
| Specify tubing: _____   | <input type="checkbox"/> 9 Other, specify: _____                          |

If equipment failure, please specify:

Equipment type: \_\_\_\_\_

Manufacturer: \_\_\_\_\_

EPINet is a trademark of the University of Virginia.  
Windows is a registered trademark of  
Microsoft Corporation in the United States and/or other countries.  
Operates in Windows 95 and Windows 98 Environments.  
© 2000 Becton, Dickinson and Company.  
V2.11 Australia/New Zealand

2/2005

- 13) How long was the blood or body fluid in contact with healthcare worker's skin or mucous membranes? (tick one)
- 1 Less than 5 minutes
  - 2 5-14 minutes
  - 3 15 minutes to 1 hour
  - 3 More than 1 hour

- 14) How much blood/body fluid came in contact with healthcare worker's skin or mucous membranes? (tick one)
- 1 Small amount (up to 5 ml, or up to 1 teaspoon)
  - 2 Moderate amount (up to 50ml, or up to quarter cup)
  - 3 Large amount (more than 50 ml)

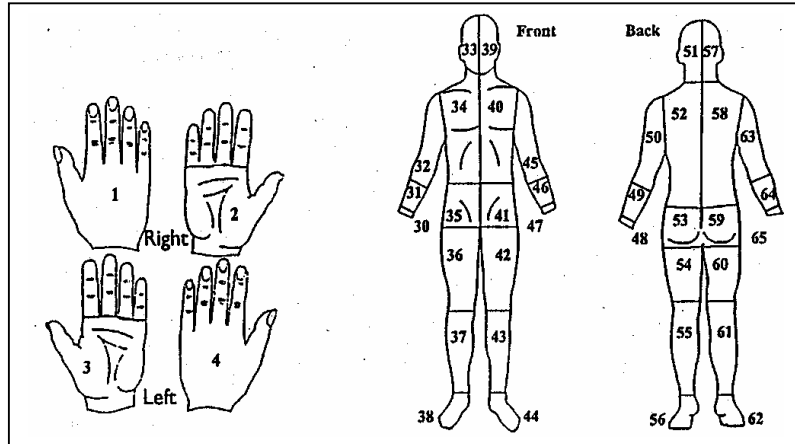
15) Location of the exposure:

Write the number of the location of up to three exposed body parts in the blanks below.

Largest area of exposure: \_\_\_\_\_

Middle area of exposure: \_\_\_\_\_

Smallest area of exposure: \_\_\_\_\_



- 16) Describe the circumstances leading to this exposure (please note if a device malfunction was involved):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 17) For injured worker: Do you have an opinion that any other engineering control, administrative or work practice could have prevented the injury?  1 Yes  2 No  3 Unknown

Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cost:

\_\_\_\_\_ **Lab charges** (HBV, HCV, HIV, other tests)

\_\_\_\_\_ Healthcare worker

\_\_\_\_\_ Source

\_\_\_\_\_ **Treatment prophylaxis** (HBIG, Hepatitis vaccines, tetanus, other)

\_\_\_\_\_ Healthcare worker

\_\_\_\_\_ Source

\_\_\_\_\_ **Service charges** (Emergency Dept, Employee Health, other)

\_\_\_\_\_ **Other costs** (Worker's Comp, surgery, other)

\_\_\_\_\_ **TOTAL** (round to nearest dollar)

Is this injury government reportable?  1 Yes  2 No  3 Unknown

Is defective medical device reporting required?  1 Yes  2 No  3 Unknown