

# Blood and Body Fluid Exposure Report/OR



Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Exposure ID: (for office use only) **B** \_\_\_\_\_ Facility ID: (for office use only) \_\_\_\_\_

1) Date of exposure:     2) Time of exposure:

- 3) Surgical service: \_\_\_\_\_
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> 1 General        | <input type="checkbox"/> 6 ENT          | <input type="checkbox"/> 11 Transplants                    |
| <input type="checkbox"/> 2 Cardiovascular | <input type="checkbox"/> 7 Neurosurgery | <input type="checkbox"/> 12 Ophthalmology                  |
| <input type="checkbox"/> 3 OB/C-Section   | <input type="checkbox"/> 8 Plastic      | <input type="checkbox"/> 13 Thoracic                       |
| <input type="checkbox"/> 4 Gynecology     | <input type="checkbox"/> 9 Urology      |  |
| <input type="checkbox"/> 5 Orthopedic     | <input type="checkbox"/> 10 Oral/Dental | <input type="checkbox"/> 99 Other service, describe: _____ |

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4) Surgical procedure being performed: \_\_\_\_\_

4a) Was it an endoscopic/laparoscopic procedure?  
 1 Yes  2 No  3 Unknown  4 Not Applicable

- 5) What is the job category of the injured worker: (check one box only)
- |   |  |                               |                                |                                |
|---|--|-------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 1 Surgeon (attending) specify specialty _____  | <input type="checkbox"/> 9 Circulating nurse at time of incident | <input type="checkbox"/> 1 RN | <input type="checkbox"/> 2 ORT | <input type="checkbox"/> 3 UAP |
| <input type="checkbox"/> 2 Surgeon (resident) specify specialty _____   | <input type="checkbox"/> 10 Scrub nurse at time of incident      | <input type="checkbox"/> 1 RN | <input type="checkbox"/> 2 ORT | <input type="checkbox"/> 3 UAP |
| <input type="checkbox"/> 3 Ob/Gyn (attending)   | <input type="checkbox"/> 11 Other Nurse                          |                               |                                |                                |
| <input type="checkbox"/> 4 Ob/Gyn (resident)  | <input type="checkbox"/> 12 Nursing Student                      |                               |                                |                                |
| <input type="checkbox"/> 5 Anesthesiologist (attending)   | <input type="checkbox"/> 13 OR Attendant                         |                               |                                |                                |
| <input type="checkbox"/> 6 Anesthesiologist (resident)  | <input type="checkbox"/> 14 Housekeeper                          |                               |                                |                                |
| <input type="checkbox"/> 7 Nurse Anesthetist  |  |                               |                                |                                |
| <input type="checkbox"/> 8 Med Student, mark rotation <input type="checkbox"/> surg <input type="checkbox"/> anesth <input type="checkbox"/> ob-gyn | <input type="checkbox"/> 99 Other, describe: _____               |                               |                                |                                |

6) If the injury was sustained by an anesthesia team member, what anesthesia task was being performed at the time of injury?  
Describe: \_\_\_\_\_

- 7) Where Did the Exposure Occur? (check one box only)
- |  |   |
|--|---|
| <input type="checkbox"/> 1 Pre-operative area                          | <input type="checkbox"/> 8 At patient's puncture site (intro of vascular cath/injection, etc) |
| <input type="checkbox"/> 2 At the mayo (instrument) stand              | <input type="checkbox"/> 9 At site of injection into IV equipment                             |
| <input type="checkbox"/> 3 At the back table                           | <input type="checkbox"/> 10 On OR floor   |
| <input type="checkbox"/> 4 In the operative site/wound                 | <input type="checkbox"/> 11 In the OR utility room  |
| <input type="checkbox"/> 5 On the surgical field (near operative site) | <input type="checkbox"/> 12 Post anesthesia care unit (recovery room)                         |
| <input type="checkbox"/> 6 On anesthesia machine                       | <input type="checkbox"/> 99 Other, describe: _____  |
| <input type="checkbox"/> 7 On anesthesia cart                          |   |

8) Was the source patient's identity known? (check one box only)  
 1 Yes  2 No  3 Unknown  4 Not Applicable

- 9) Which body fluids were involved in the exposure? (check all that apply)
- |  |   |
|--|---|
| <input type="checkbox"/> Blood or blood products | <input type="checkbox"/> Peritoneal fluid       |
| <input type="checkbox"/> Vomit/gastric contents  | <input type="checkbox"/> Pleural fluid          |
| <input type="checkbox"/> Sputum                  | <input type="checkbox"/> Amniotic fluid         |
| <input type="checkbox"/> Saliva                  | <input type="checkbox"/> Urine                  |
| <input type="checkbox"/> CSF                     | <input type="checkbox"/> Other, describe: _____ |

Was the body fluid visibly contaminated with blood?  Yes  No  Unknown

- 10) Was the exposed part: (check 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, describe: _____ |

- 11) Did the blood or body fluid: (check 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/undergarments                |
| <input type="checkbox"/> Touch skin through tear in glove              |   |

- 12) Which barrier garments were worn at the time of exposure: (check all that apply)
- |   |  |
|---|--|
| <input type="checkbox"/> Single pair latex/vinyl gloves     | <input type="checkbox"/> Surgical mask                         |
| <input type="checkbox"/> Double pair latex/vinyl gloves     | <input type="checkbox"/> Surgical mask with attached eyeshield |
| <input type="checkbox"/> Goggles                            | <input type="checkbox"/> Surgical gown, disposable             |
| <input type="checkbox"/> Eyeglasses (not a protective item) | <input type="checkbox"/> Surgical gown, reusable               |
| <input type="checkbox"/> Eyeglasses with side shields       |  |
| <input type="checkbox"/> Face shield                        | <input type="checkbox"/> Other, describe: _____                |

- 12a) If surgical gown, was it?
- |  |  |
|--|--|
| <input type="checkbox"/> 1 Fabric, standard single layer | <input type="checkbox"/> 3 Plastic, reinforced/coated                    |
| <input type="checkbox"/> 2 Fabric, reinforced            | <input type="checkbox"/> 4 Composite construction (multi-layer laminate) |

**13) Was the exposure the result of:** (check one box only)

- 1 Direct patient contact
- 2 Touched contaminated equipment/surface
- 3 Touched contaminated drapes/sheets/gowns, etc.
- 4 Specimen container leaked/spilled/broke
- 5 Tubing (*blood, suction, drain, etc.*) leaked/disconnected/broke
- 6 Bag/pump leaked/spilled/broke
- 7 Trach/NG tubing broke/sprayed
- 8 Suction canister spilled/leaked/broke
- 9 Other irrigation/fluid container spilled/leaked/broke
- 10 Other equipment/operator failure
- 11 Unknown
- 99 Other, describe: \_\_\_\_\_

If equipment failure, please specify: **Equipment type:** \_\_\_\_\_

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

**14) For how long was the blood or body fluid in contact with your skin or mucous membranes?** (check one)

- 1 Less than 5 minutes
- 2 5-14 minutes
- 3 15 minutes to 1 hour
- 4 More than 1 hour

**15) How much blood/body fluid came in contact with your skin or mucous membranes?**(check one)

- 1 Small amount (up to 5 cc, or up to 1 teaspoon)
- 2 Moderate amount (up to 50 cc, or up to quarter cup)
- 3 Large amount (more than 50 cc)

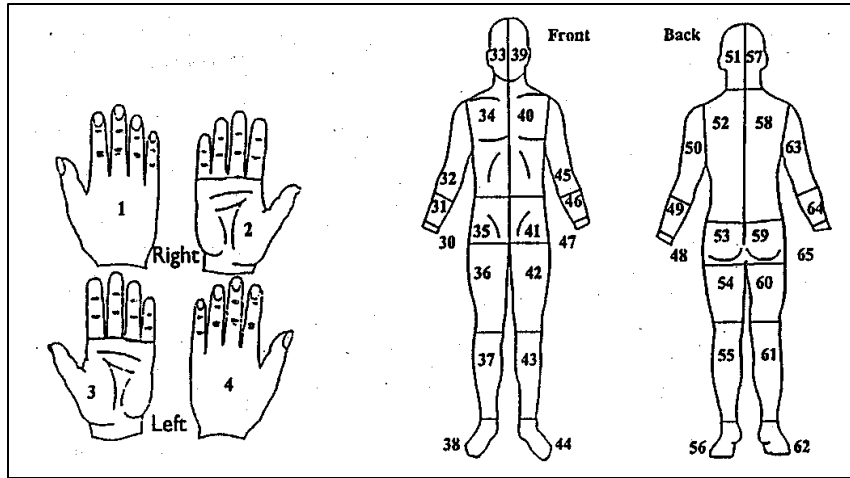
**16) Location of the exposure:**

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: \_\_\_\_\_



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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Cost:**

\_\_\_\_\_ **Lab charges** (*Hb, HCV, HIV, other tests*)  
 \_\_\_\_\_ Healthcare worker  
 \_\_\_\_\_ Source

\_\_\_\_\_ **Treatment prophylaxis** (*HBIG, Hb vaccine, 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 incident OSHA reportable?  1 Yes  2 No  3 Unknown

If yes, days away from work? \_\_\_\_\_  
 Days of restricted work activity? \_\_\_\_\_

Does this incident meet the FDA medical device reporting criteria? (Yes if a device defect caused serious injury necessitating medical or surgical intervention, or death occurred within 10 works days of incident.)

- 1 Yes (If yes, follow FDA reporting protocol)
- 2 No