# ORVIS SCHOOL OF NURSING

# BLOOD BORNE PATHOGEN & COMMUNICABLE DISEASE

# STUDENT EXPOSURE REPORTING FORM

* This form must be completed by the student in collaboration with clinical faculty for any exposure or potential exposure to a communicable disease that occurs during the course of a clinical rotation. An exposure or potential exposure is defined as a percutaneous injury or direct skin and/or mucous membrane contact with blood or body fluids or a reasonable belief that an exposure may have occurred.
* Please complete this form as thoroughly as possible. This form is required in addition to any form required by your clinical agency.
* While your first priority is to obtain appropriate exposure management and post-exposure prophylaxis therapy if indicated, this form must be completed prior to leaving clinical on the day that the injury or exposure occurred.
* This information will remain confidential and will be maintained in a locked cabinet at the Orvis School of Nursing for a period of not less than ten years following the exposure. Information in this form will remain confidential and will only be utilized by public health agencies in the mandated reporting of diseases, or as required by law.
1. Name of exposed individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of exposure: \_\_­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of exposure: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Exact location where exposure occurred (i.e patient room #, hallway, utility room):
3. What specific area of the student’s body was exposed (i.e. left index finger, mucosa of right eye)?
4. Witnesses to exposure incident:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Describe the circumstances of the exposure:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# THE FOLLOWING SECTION IS APPLICABLE ONLY TO SHARP OBJECT INJURIES. IF THIS EXPOSURE WAS NOT THE RESULT OF A SHARP OBJECT INJURY, PLEASE CONTINUE TO PAGE 3.

1. Was the injured worker the original user of the sharp item?

 🞎 Yes 🞎 No 🞎 Unknown 🞎 Not applicable

1. The sharp item was:

 🞎 Contaminated 🞎 Uncontaminated 🞎 Unknown 🞎 Not applicable

1. For what purpose was the sharp item originally used:

 🞎 Unknown 🞎 To connect IV line

 🞎 Injection into muscle, vein, or artery 🞎 To gain intravenous access

 🞎 Heparin or saline flush 🞎 To draw a venous blood sample

 🞎 Injection into (or aspiration from) 🞎 To draw an arterial blood sample, IV injection site or IV port

1. Did the injury occur:

 🞎 Before use of item 🞎 Device left on floor, table, or bed

🞎 During use of item 🞎 In transit to disposal

 🞎 After use of item 🞎 While disposing of item

 🞎 Between steps of a multi-step procedure 🞎 After disposal/protruding from

🞎 While recapping a used needle sharps container

 🞎 While withdrawing needle from a rubber port 🞎 Other: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What type of device cased the injury?

🞎 Hollow Bore Needle 🞎 Surgical Needle 🞎 Lancet 🞎 Glass

1. Brand/Manufacturer of product (i.e. ABC Medical Company):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞎 Unknown

1. If the item causing the injury was a needle or a sharp medical device, was it a “safety design” with a shielded, recessed, retractable, or blunted needle or blade?

🞎 Yes 🞎 No 🞎 Unknown

* 1. Was the protective mechanism activated?

 🞎 Yes, fully 🞎 No

🞎 Yes, partially 🞎 Unknown

* 1. Did exposure incident happen

 🞎 Before activation 🞎 During activation

 🞎 After activation 🞎 N/A

# THE FOLLOWING SECTION IS APPLICABLE ONLY TO BLOOD AND/OR BODY FLUID EXPOSURES TO SKIN OR MUCOUS MEMBRANES. IF THIS EXPOSURE WAS THE RESULT OF A SHARP OBJECT INJURY, PLEASE CONTINUE TO PAGE 4

1. Which body fluids were involved in the exposure?

🞎 Blood or blood products 🞎 Saliva 🞎 Peritoneal fluid

🞎 Vomit 🞎 Sputum 🞎 Pleural fluid

🞎 Amniotic fluid 🞎 CSF 🞎 Urine

🞎 Other: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Was the body fluid visibly contaminated with blood?

 🞎 Yes 🞎 No 🞎 Unknown 🞎 Not applicable

1. Was the exposed part:

 🞎 Intact skin 🞎 Eyes (conjunctiva) 🞎 Nose (mucosa)

 🞎 Non-intact skin 🞎 Mouth (mucosa) 🞎 Other: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did the blood or body fluid: 🞎 Touch unprotected skin 🞎 Soak through protective barrier garment 🞎 Touch skin between gap in PPE 🞎 Soak through clothing

1. Which barrier garments, if any, were worn at the time of exposure: 🞎 Latex/vinyl gloves 🞎 Face shield 🞎 Protective gown 🞎 Goggles 🞎 Surgical mask 🞎 Lab coat 🞎 Eyeglasses 🞎 Other: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If the exposure was the result of an equipment failure, please specify:

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

1. For how long the was the contaminated substance in contact with your skin or mucous membranes: 🞎 < 5 minutes 🞎 5 – 15 minutes 🞎 15 minutes – 1 hour 🞎 > 1 hour
2. How much blood/body fluid came in contact with your skin or mucous membranes?

🞎 Small amount (< 5 cc) 🞎 Moderate amount (up to 50 cc) 🞎 Large amount (> 50 cc)

# SOURCE PATIENT DATA & POST-EXPOSURE FOLLOW UP

1. Name of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Date of injury: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Was the source patient identifiable

 🞎 Source known and tested

 🞎 Source known, but not tested

 🞎 Source not known

1. Was the source patient known to be positive for any of the following pathogens

(check all that apply):

 🞎 Hepatitis B 🞎 Respiratory tuberculosis

 🞎 Hepatitis C 🞎 Bacterial meningitis

 🞎 HIV 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If the source patient was believed to be in a high risk group for a blood-borne pathogen, please check all that apply:

🞎 Blood product recipient 🞎 Hemophilia

🞎 Injection drug use 🞎 Sexual history

🞎 Elevated liver enzymes 🞎 Dialysis

🞎 Other: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If the source patient was known to be HIV+, has s/he been treated with any of the following:

🞎 Zidovudine 🞎 Not applicable

🞎 3TC 🞎 Unknown

🞎 ddC Other anti-retroviral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 IDV

Student seen and exposure evaluated by (check all that apply): 🞎 UNR Student Health 🞎 Clinical agency employee health 🞎 Private health care provider 🞎 No follow-up care received 🞎 Emergency room 🞎 Other: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Was the student vaccinated against HBV before exposure?

 🞎 No 🞎 1 Dose 🞎 2 Doses 🞎 3 Doses

1. Was the student pregnant at the time of the exposure?

 🞎 Yes, 1st trimester 🞎Yes, 2nd trimester 🞎 Yes, 3rd trimester 🞎 No 🞎 Not applicable

1. What follow up care was received after evaluation of this exposure:

 🞎 None 🞎 Other prophylaxis: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 Baseline testing only

🞎 HAART post-exposure prophylaxis 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

April 12, 2006