Appendix 1

Possible Exposure to Reportable Disease/Follow-Up

Employee name_____ SS#_____

Home phone: _____ Work phone: _____

Department: _____

Date & time of exposure ____/____/____ ____: ____ am / pm Location:_____

Type of Exposure: Needle Stick Laceration Bite Splash Other _____

Circumstances of Exposure:

_____

_____

_____

Identifiable Source

Name: _____ Location: _____

Blood Contamination screen drawn on source? Yes No

Attending MD Name: _____

Known Communicable Disease: _____

TEXAS Department of State Health Services

INFECTIOUS DISEASE CONTROL

CONTAMINATED SHARPS INJURY REPORTING FORM

The facility where the injury occurred should complete the form and submit it to the local health authority where the facility is located. If no local health authority is appointed for this jurisdiction, submit to the regional director of the Texas Department of State Health Services (DSHS) regional office in which the facility is located. Address information for regional directors can be obtained on the DSHS webpage at http://www.dshs.state.tx.us/regions/default.shtm. The local health authority, acting as an agent for the Texas Department of State Health Services will receive and review the report for completeness, and submit the report to: IDEAS, Texas DSHS, 1100 West 49th Street, T-801, Austin, Texas 78756-3199. Obtain copies at http://www.dshs.state.tx.us/idcu/health/infection_control/bloodborne_pathogens/reporting or from Texas Department of State Health Services regional offices.

Please complete a form for each exposure incident involving a sharp.

NOTE: If the injury occurred BEFORE the sharp was used for its original intended purpose, *do not* submit this form

Facility (agency/institution) **where injury occurred:**		
Street address (no post office box):		
City:	**County:**	**Zip code:**
Street address of reporter if different from facility where injury occurred:		
Date:	Reporter's Name:	
	Reporter's Telephone:	Reporter's e-mail:
1. Date of injury:	**Time of injury:** ☐am ☐ pm	**Age of injured:** / **Sex of injured:** ☐ M ☐ F
2. Type and Brand of sharp involved (*Check one box*)		**List brand name of sharp:**

Needles

- ☐ Arterial catheter introducer needle
- ☐ Blood gas syringe
- ☐ Central line catheter needle (cardiac, etc.)

Disposable Syringe

- ☐ Insulin
- ☐ 20-gauge needle
- ☐ 21-gauge needle
- ☐ 22-gauge needle
- ☐ 23-gauge needle
- ☐ 24/25-gauge needle
- ☐ Tuberculin

- ☐ Drum catheter needle
- ☐ IV catheter stylet
- ☐ Needle on IV line (includes piggybacks & IV line connectors
- ☐ Needle, not sure what kind
- ☐ Pre-filled cartridge syringe
- ☐ Spinal or epidural needle
- ☐ Suture needle
- ☐ Syringe, other type
- ☐ Unattached hypodermic needle
- ☐ Vacuum tube blood collection holder/needle
- ☐ Winged steel needle (includes butterfly, winged-set type devices)

Other

- ☐ Other vascular catheter needle (cardiac, etc.)
- ☐ Other non-vascular catheter needle (ophthalmology, etc.)
- ☐ Other nonsuture _____

Surgical Instruments *(or other sharp items)*

- ☐ Bone chip/chipped tooth
- ☐ Bone cutter
- ☐ Drill bit/bur
- ☐ Electro-cautery device
- ☐ Fingernails/teeth
- ☐ Huber needle
- ☐ Lancet (finger or heel stick)
- ☐ Microtome blade
- ☐ Pickups/forceps/ hemostats/clamps
- ☐ Pin (fixation, guide pin)
- ☐ Pipette (plastic)
- ☐ Razor
- ☐ Retractors, skin/bone hooks
- ☐ Scalpel, disposable
- ☐ Scalpel, reusable
- ☐ Scissors
- ☐ Sharp item, not sure what kind
- ☐ Specimen/test tube (plastic)
- ☐ Staples/steel sutures
- ☐ Towel clip
- ☐ Trocar
- ☐ Vacuum tube (plastic)
- ☐ Wire (suture/fixation/guide wire)
- ☐ Other sharp _____

Glass

- ☐ Capillary tube
- ☐ Glass slide
- ☐ Glass item, not sure what kind
- ☐ Medication ampule/vial/IV bottle
- ☐ Pipette
- ☐ Specimen/test tube
- ☐ Vacuum tube
- ☐ Other glass item: _____

3. Original intended use of sharp (*check one box)*

☐ Connect IV line (intermittent IV/piggyback/IV infusion/other IV line connection

☐Contain a specimen or pharmaceutical (glass item)

☐ Cutting

☐ Dental ☐ Extraction ☐ Hygiene ☐ Orthodontic ☐ Periodontal ☐ Restorative ☐ Root Canal

☐ Dialysis

☐ Draw arterial blood sample…*if used to draw blood was it* ☐ direct stick *or* ☐ drawn from a line

☐ Draw venous blood sample

☐ Drilling

☐ Electrocautery

☐ Finger Stick/heel stick

☐ Heparin or saline flush

☐ Injection, intra-muscular/subcutaneous/intra-dermal, or other injection through the skin (syringe)

☐ Obtain a body fluid or tissue sample (urine/CSF/amniotic fluid/other fluid, biopsy)

☐ Other injection into (or aspiration from) IV injection site or IV port (syringe)

☐ Remove central line/porta catheter

☐ Start IV or set up heparin lock (IV catheter or winged set-type needle)

☐ Suturing ☐ deep ☐ skin

☐ Tattoo

☐ Unknown/not applicable

☐ Wiring

☐ Other _____

4. When and How Injury Occurred…

☐ Before (DO NOT report to DSHS) ☐ during ☐ after the sharp was used for its intended purpose

If the exposure occurred during or after the sharp was used, was it (*check one box*)

☐ Activating safety device

☐ Between steps of a multistep procedure (carrying, handling, passing/receiving syringe/instrument, etc.)

☐ Device malfunctioned

☐ Device pierced the side of the disposal container

☐ Disassembling device or equipment

☐ Found in an inappropriate place (eg. Table, bed, linen, floor, trash)

☐ Interaction with another person

☐ Laboratory procedure/process

☐ Patient moved during the procedure

☐ Preparation for reuse of instrument (cleaning, sorting, disinfecting, sterilizing, etc.)

☐ Recapping

☐ Suturing

☐ Use of sharps container

☐ Unsafe practice

☐ Use of IV/central line

☐ Other _____

5. Did the device being used have engineered sharps injury protection? ☐ yes ☐ no ☐ do not know

A. Was the protective mechanism activated? ☐ yes ☐ no ☐ do not know

B. Did the exposure incident occur ☐ before ☐ during ☐ after activation of the protective mechanism

6. Was the injured person wearing gloves? ☐ yes ☐ no ☐ do not know

7. Had the injured person completed a hepatitis B vaccination series? ☐ yes ☐ no ☐ do not know

8. Was there a sharps container readily available for disposal of the sharp? ☐ yes ☐ no

Did the sharps container provide a clear view of the level of contaminated sharps? ☐ yes ☐ no

9. Had the injured person received training on the exposure control plan in the 12 months prior to the incident? ☐ yes ☐ no

10. Involved body part (*check one box*) ☐ hand ☐ arm ☐ leg/foot ☐ face/head/neck ☐ torso (front or back)

11. Job Classification of injured person (*check only one box*)

- ☐ Aide (e.g. CAN, HHA, orderly)
- ☐ Attending physician (MD, DO)
- ☐ Central supply
- ☐ Chiropractor
- ☐ Clerical/administrative
- ☐ Clinical lab technician
- ☐ Counselor/social worker
- ☐ CRNA/NP
- ☐ Dentist
- ☐ Dental assistant/technician
- ☐ Dental hygienist
- ☐ Dental student
- ☐ Dietician
- ☐ EMT/ paramedic
- ☐ Fellow
- ☐ Firefighter
- ☐ Food service
- ☐ Hemodialysis technician
- ☐ Housekeeper/laundry
- ☐ Intern/resident
- ☐ Law enforcement officer
- ☐ Licensed vocational nurse
- ☐ Maintenance staff
- ☐ Medical student
- ☐ Morgue tech/autopsy tech
- ☐ Nurse midwife
- ☐ Nursing student
- ☐ OR/surgical technician
- ☐ Pharmacist
- ☐ Physician assistant
- ☐ Physical therapist
- ☐ Phlebotomist/venipuncture/IV team
- ☐ Psychiatric technician
- ☐ Public health worker
- ☐ Radiologic technician
- ☐ Registered nurse
- ☐ Researcher
- ☐ Respiratory therapist/technician
- ☐ Safety/security
- ☐ School personnel (not nurse)
- ☐ Transport/messenger
- ☐ Volunteer
- ☐ Other _____

12. Employment Status of Injured Person (*check one box*)

☐ Employee ☐ Student ☐ Contractor/contract employee ☐ Volunteer ☐ Other _____

If not directly employed by reporter, name the employer/service/agency/school: _____

13. Location/Facility/Agency in which sharps injury occurred (*check one box*)

- ☐ Blood bank/center/mobile
- ☐ Clinic
- ☐ Correctional facility
- ☐ Dental facility
- ☐ EMS/Fire/Police
- ☐ Home health
- ☐ Hospital
- ☐ Laboratory (freestanding)
- ☐ Medical examiner office/morgue
- ☐ Outpatient treatment (e.g. dialysis, infusion therapy)
- ☐ Residential facility (e.g. MHMR, shelter)
- ☐ School/college
- ☐ Other _____

14. Work Area where Sharps Injury Occurred *(check one box)*

- ☐ Ambulance
- ☐ Autopsy/pathology
- ☐ Blood bank center/mobile
- ☐ Central supply
- ☐ Critical care unit
- ☐ Dental clinic
- ☐ Dialysis room/center
- ☐ Emergency department
- ☐ Endoscopy/bronchoscopy/ cystoscopy
- ☐ Field (non EMS)
- ☐ Floor (not patient room)
- ☐ Home
- ☐ Infirmary
- ☐ Jail unit
- ☐ Laboratory
- ☐ L & D/Gynecology unit
- ☐ Medical/Outpatient clinic
- ☐ Medical/surgical unit
- ☐ Nursery
- ☐ Patient/resident room
- ☐ Pediatrics
- ☐ Pre-op or PACU
- ☐ Procedure room
- ☐ Rescue setting (non ER)
- ☐ Radiology department
- ☐ Seclusion room/psychiatric unit
- ☐ Service/Utility area (e.g. laundry)
- ☐ Surgery/operating room
- ☐ Other _____

COMMENTS:

Appendix 3
REPORT OF POSSIBLE EXPOSURE TO TRANSPORTER

Any transporter who has one of the exposures listed in #2 below must complete this form immediately. The completed form should be placed in the designated receptacle provided by the hospital where the patient is delivered. Items 1-5 are to be completed by the transporter. Questions in the box are to be completed by the hospital.

Please Print Legibly

Items 1-5 to be completed by the Transporter.

1. The exposure described in #2 below occurred in the care of the following patient/person:
____ on ____/____/____ at
(Patients Name)
________am/pm taken to: ____
(Facility)

- -

Hospitals: Cut on dotted line and send this lower portion only to the health authority.
You may wish to keep a copy for your records.

2. Describe the details of contact with blood or body fluids.

TYPE OF EXPOSURE (Check those that apply)	ADDITIONAL DESCRIPTION
____ Mouth to mouth resuscitation	___________________________
____ Intubation	___________________________
____ Throat Exam	___________________________
____ Suctioning	___________________________
____ Blood and/or	
____ body fluid contact with:	
____ Eyes	___________________________
____ Nose	___________________________
____ Mouth	___________________________
____ Puncture/cut w/needle or sharp object	___________________________
____ Open wound lesion	___________________________
____ Non-intact skin	___________________________

Self-first aid must be done as soon as possible following one of the above exposures. Rinse/Flush thoroughly the body part exposed to blood or body fluids.
Follow with anti-microbial scrubbing of the exposed area, if not contraindicated, (i.e. eyes, etc.)

3. Transporter Name: ____
Telephone: (home)____________________________(work)___________________________
4. Name of Employer/Agency (EMS/Fire/Police): ____________________________________
Address: _______________________ City: ___________________Phone: _______________

5. Transporter Signature: __________________________Date form completed: ___________
Transporter; Now place form in designated receptacle

TO BE COMPLETED BY THE HOSPITAL:

____ DISEASE IDENTIFIED ______________________________ ____/____/_____
(Name of disease) (Date specimen collected)
____ NO DISEASE IDENTIFIED DURING THIS HOSPITALIZATION

REPORTED TO HEALTH AUTHORITY BY TELEPHONE (for true exposures only)
Name of Agency __________________________Person Contacted ____________________
Date Contacted ____/____/____ By: ____________________________
Name/Title of Person completing this Section: ____________________________________
Signature: ____ Date ____/____/____

Appendix 4

BBP Form

Date: _____

Trainer(s):_____

BBP Training Class □ **Annual Review** □

Print Name	Department	Social Security #	Signature

Appendix 5

Infection Control Telephone Contacts

The primary contact for Infection Control information is Risk Management:

Safety Manager (Jacque Darbonne) – 713-274-5532
Risk Manager (Tamara Ross) – 713-274-5464