INJURY / EXPOSURE EVENT REPORT

TO BE COMPLETED BY EMPLOYEE: EVENT DETAILS

EMPLOYEE NAME: _____ **DOB:** _____ **EVENT DATE:** _____

INJURY	EXPOSURE TO BBP
☐ **Musculoskeletal Sprain / Strain**	☐ **Needlestick** (Page 3 required)
☐ **Violence / Abuse** from: ☐ Patient ☐ Caregiver / Family Member	☐ **Contact with Mucous Membrane**: ☐ Eye ☐ Nose ☐ Mouth
☐ **Slip / Trip / Fall**: ☐ Entering / Exiting Residence ☐ Inside the Residence ☐ Other: _____	☐ **Contact with (non-intact) skin**
☐ **Automobile Accident** traveling: from:_____ to _____	☐ **Other**: _____
☐ **Other**:	

Describe the job duties being performed when the injury / exposure occurred:

Describe how the injury / exposure occurred:

COMPLETE FOR EXPOSURE EVENT

Have you been vaccinated against Hepatitis B (HBV)? ☐ Yes ☐ No ☐ Don't Know

If yes, was the vaccination series completed? ☐ Yes ☐ No ☐ Don't Know

If yes, please provide date(s) of vaccination (if known):

By law, you have the right to a confidential medical evaluation, including baseline blood collection / testing with or without giving consent for Human Immunodeficiency Virus (HIV) testing.

Do you consent to baseline blood collection? ☐ Yes ☐ No

Do you consent to HIV testing? ☐ Yes ☐ No

Identity of person whose blood / bodily fluid you were exposed to:

Name: _____ DOB: _____ Phone: _____

Is this person willing to be tested for HIV, HBV, or other bloodborne pathogens? ☐ Yes ☐ No ☐ Didn't Ask

Is this person already known to be infected with HIV / HBV? ☐ Yes ☐ No ☐ Didn't Ask

_____ _____

Employee Signature Date

INJURY / EXPOSURE EVENT REPORT

TO BE COMPLETED BY MEDICAL PROVIDER: MEDICAL EVALUATION

EMPLOYEE NAME: _____ **DOB:** _____ **EVALUATION DATE:** _____

EXPOSURE TO BBP

☐ Not Applicable

Was the potentially exposed person counselled regarding options for HIV / HBV testing? ☐ Yes ☐ No

Was the potentially exposed person educated on medical conditions that may result from exposure and options for evaluation and treatment? ☐ Yes ☐ No

Was testing recommended during this evaluation? ☐ Yes ☐ No

If yes, was testing conducted during this evaluation visit? ☐ Yes ☐ No

If no, please explain why:

INJURY / EXPOSURE TO BBP

When is the employee able to resume nursing duties?

- ☐ Immediately, no Restrictions
- ☐ Immediately, w/ Restrictions as noted below
- ☐ Date: _____

Was additional medical care / follow-up recommended?

☐ Yes ☐ No

Did the injured / exposed person decline any medical advice / care? ☐ Yes ☐ No

Provider Evaluation Comments for Employer:

_____

Provider Signature & Credentials

EMPLOYEE DECLINATION

Helms Home Care recommends employees seek medical attention following any workplace injury or exposure and explained to this employee that all costs related to a workplace injury / exposure including evaluation, testing, and follow-up care would be covered by Helms Home Care.

By signing below, the above-named employee declines / refuses medical attention following the injury / exposure event documented on page 1 of this Event Report.

_____ _____

Employee Signature Date

INJURY / EXPOSURE EVENT REPORT

TO BE COMPLETED BY EMPLOYEE*: SHARPS REPORT

*Needlestick / Sharps Injury Only

EMPLOYEE NAME: _____ **DOB:** _____ **EVENT DATE:** _____

Procedure Being Performed When Injury Occurred:

- ☐ Draw venous blood
- ☐ Draw arterial blood
- ☐ Injection, through skin
- ☐ Start IV/set up Saline Lock
- ☐ Unknown/not applicable
- ☐ Heparin/Saline Flush
- ☐ Cutting
- ☐ Suturing
- ☐ Other:

Did the Exposure Incident Occur:

- ☐ During use of sharp
- ☐ Between steps of a multistep procedure
- ☐ After use and before disposal of sharp
- ☐ While putting sharp into disposal container
- ☐ Sharp left in inappropriate place (table, bed, etc.)
- ☐ Disassembling
- ☐ Other:

Was sharp contaminated (exposure to patient / blood on device)?

- ☐ Yes
- ☐ No
- ☐ Unknown

Body Part(s)

- ☐ Finger
- ☐ Hand ☐ R ☐ L
- ☐ Arm ☐ R ☐ L
- ☐ Face/Head
- ☐ Torso
- ☐ Leg ☐ R ☐ L

Identify Sharp Involved (if known):

Type: _____

Brand: _____

Model: _____

Did sharp have engineered injury protection?

- ☐ Yes
- ☐ No
- ☐ Don't know

Was the protective mechanism activated?

- ☐ Yes, fully
- ☐ Yes, partially
- ☐ No

Did the exposure incident occur:

- ☐ Before
- ☐ During
- ☐ After activation

If sharp had no engineered injury protection, do you believe that such a mechanism could have prevented the injury?

- ☐ Yes
- ☐ No

Do you believe that any other engineering, administrative or work practice control could have prevented the injury?

- ☐ Yes
- ☐ No

_____ _____

Employee Signature Date