TTU
POST EXPOSURE PACKET

USE FOR THE FOLLOWING:
STUDENTS
TTU EMPLOYEE

PLEASE RETURN TO:

TTU Environmental Health and Safety
TTU Mail Stop: 1090
Telephone: #742-3876
### First Report of Injury/Illness/Accident

Submit Completed form to: Texas Tech University System, Risk Management Department, MS 2003, Lubbock, Texas (FAX: 806-742-3018)

Please print or type

<table>
<thead>
<tr>
<th>1. Name (Last, First, MI)</th>
<th>2. Sex: □ Female □ Male</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>3. SSN</th>
<th>4. Home Phone</th>
<th>5. Date of Birth</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>6. Mailing Address (Home)</th>
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<tbody>
<tr>
<td>City: ____________________ State: _____ Zip Code: ______________</td>
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<table>
<thead>
<tr>
<th>7. Marital Status</th>
<th>8. Number of Dependent Children?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Married □ Single □ Separated □ Divorced □ Widowed</td>
<td></td>
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<table>
<thead>
<tr>
<th>9. Spouse's Name</th>
<th>10. Does the employee speak English?</th>
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<tbody>
<tr>
<td></td>
<td>If no, specify language □ Yes □ No</td>
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<table>
<thead>
<tr>
<th>11. Department</th>
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<table>
<thead>
<tr>
<th>12. Office Phone</th>
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<thead>
<tr>
<th>13. Supervisor's Name</th>
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<table>
<thead>
<tr>
<th>14. Date of Accident</th>
<th>15. Time of Accident</th>
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<tbody>
<tr>
<td></td>
<td>□ AM □ PM</td>
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<table>
<thead>
<tr>
<th>16. Was employee doing his/her regular job?</th>
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</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
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</table>

<table>
<thead>
<tr>
<th>17. Address where accident or exposure occurred.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of business if accident occurred in a business site.</td>
</tr>
<tr>
<td>City: ____________________ State: _____ Code: __________</td>
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<table>
<thead>
<tr>
<th>18. Cause of accident (struck, fall, strain, etc.)</th>
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<table>
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<tr>
<th>19. How and why Accident/Exposure occurred?</th>
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<table>
<thead>
<tr>
<th>20. Part of body injured or exposed</th>
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<table>
<thead>
<tr>
<th>21. List Witnesses</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>22. Date Reported to Supervisor</th>
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<table>
<thead>
<tr>
<th>23. Print Name and Title of person Completing Form</th>
<th>Date</th>
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<thead>
<tr>
<th>24. Signature of person Completing Form</th>
<th>Date</th>
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</table>

Complete the following sections ONLY IF medical treatment or lost time from work is involved.

<table>
<thead>
<tr>
<th>25. Treating Doctor Name</th>
<th>26. Date Lost Time Began</th>
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<tbody>
<tr>
<td>_________________________</td>
<td>_________________________</td>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Phone Number:</th>
<th>27. Return to work date or expected date</th>
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**NOTE:** With few exceptions, you are entitled by law to know, review, and correct information that we collect about you. For more information, please refer to TTU OP 01.04 or TTUHSC OP 01.03
TTU Bloodborne Pathogen Exposure Investigation

Exposed person, please fill out the following information: **Today’s Date:**

(Your) Name: ___________________________________________________________

Date of your last tetanus: ______________ Date of your Hep B series: __________

Date and time of exposure: ________________________________________________________________________

Location of exposure: (ER, OR, Unit, etc.) _________________________________________________________

Describe how the exposure occurred, including needle stick or splash, during a procedure?

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Was the exposure **PERCUTANEOUS** or **MUCOUS MEMBRANE**?

(Circle one of the above)

What part of the body was exposed?

_______________________________________________________________________

Were you using a **SOLID** or **HOLLOW BORNE** needle or instrument?

(Circle one of the above)

Would you consider the wound **SUPERFICIAL** or **DEEP**?

(Circle one of the above)

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Name of source patient: _______________________________________________________

Contact information of source patient: _________________________________________

Known source patient risk factors? (HIV, Hep B, Hep C) _______________________

Notes: ___________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
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](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](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:**

**Street address of reporter if different from facility where injury occurred:**

**Reporter's Name:**

**Date:**

** Reporter's Telephone:**

**Reporter's e-mail:**

1. **Date of injury:**

2. **Type and Brand of sharp involved (Check one box)**

   - 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 (included piggyback & 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

   - Bone chip/chipped tooth
   - Bone cutter
   - Drill bit/bur
   - Electro-cautery device
   - Fingernails/teeth
   - Huber needle
   - Lancet (finger or heel stick)
   - Microtome blade
   - Pickup/forceps/s hemostats/clamp
   - Pin (fixation, guide pin)
   - Pipette
   - Razor
   - Retractors, skin/bone hooks
   - Scissors
   - Scalpel, disposable
   - Scalpel, reusuable
   - 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

   **Age of injured:**

   **Sex of injured: □ M □ F**

9/2/2010
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 (rine/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

When and How Injury Occurred...

☐ Before (DO NOT report to DSH) ☐ 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 sharps? ☐ 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
- Employee
- Student
- Contractor/contract employee
- 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
- Laboratory
- Laboratory (freestanding)
- Medical examiner office/morgue
- Medical/surgical unit
- Medical/Outpatient clinic
- Medical/surgical unit
- Nursery
- Patient/resident room
- Patient/resident room
- Pediatrics
- Rescue setting (non ER)
- Resident (e.g. dialysis, infusion therapy)
- Residential facility (e.g. MHMR, shelter)
- School/college
- School personnel (not nurse)
- Service/Utility area (e.g. laundry)
- Surgery/operating room
- 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
- Labor
- L & D/Gynecology unit
- Medical/Outpatient clinic
- Medical/surgical unit
- Nursery
- Patient/resident room
- Patient/resident room
- Pediatrics
- Pre-op or PACU
- Procedure room
- Radiology department
- Seclusion room/psychiatric unit
- Service/Utility area (e.g. laundry)
- Other

COMMENTS:

8/21/2009
Exposed person, please initial each item. Contact Environmental Health & Safety at 742-3876 IMMEDIATELY or call TTU Police at 742-3931

__________ 1. Make sure that source patient blood is drawn by clinic personnel (HIV, BSAG, HCV). Draw 2 tiger tops.

__________ 2. Begin filling out the forms enclosed in this packet and you will be advised what to do next by Health and Safety Personnel at Environmental Health and Safety (EH&S) or call TTU Police at 742-3931.

__________ 3. If unable to reach EH&S, or it is after 5pm, exposed person go to UMC/ER STAT

First thing next business day, contact TTU Environmental Health & Safety at 742-3876 to report, obtain source lab information and coordinate follow/up.

•Pink lab requisition for Exposed person
•White lab requisition for Source patient
UMC Clinical Laboratory Instructions: After 5:00pm and on holidays and weekends, please spin down and hold in Rapid Response refrigerator Until the next business day, then transport specimen to TTUHSC Pathology (1A-115)

UMC DO NOT ORDER OR PERFORM THE TESTS.
Texas Tech University
Employee Health/Infection Control Requisition
(Pink Lab Requisition Form)

<table>
<thead>
<tr>
<th>Information below must be completed</th>
<th>Exposed Person Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Drawn: ________________________</td>
<td>Name: ______________________</td>
</tr>
<tr>
<td>Date Specimen Collected: ___________</td>
<td>SS#: ________________________</td>
</tr>
<tr>
<td>By: ______________________________</td>
<td>DOB: ________________________</td>
</tr>
<tr>
<td>Request Completed by: _____________</td>
<td>Ordering physician: _________</td>
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<tr>
<td>Source: □ Blood</td>
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Exposed Person Laboratory Request

- PEP Protocol Labs
  - (2 tiger top and 1 purple top tubes)
  - _____ Hepatitis B Surface Antibody BSAB
  - _____ Hepatitis C
  - _____ HIV
  - _____ CBC
  - _____ ALT
  - _____ Creatinine

OR

- Unknown Exposure
  - (2 tiger top tubes)
  - _____ Hepatitis B Surface Antibody
  - _____ Hepatitis C
  - _____ HIV