GASTROENTERITIS OUTBREAK LINE LIST (PATIENTS/RESIDENTS)

Complete and fax daily to Infection Prevention and Control

Facility Name:_____ **Unit:**_____ **Telephone**:_____

Contact Person:_____ **Telephone**:_____

DEMOGRAPHICS (one line per patient/resident)		Stool or Vomitus Spec	SIGNS & SYMPTOMS		ACUTE SUDDEN ONSET CLINICAL SYMPTOMS (✓tick all applicable & record # of episodes in a 24 hr period)					Acute Adm/ Tsfr Date	Comments /Other
NAME (LAST, First) MRN & PHN	ROOM BED #	SENT DATE	Onset Date & Time	Resolved Date	ABD Pain	Nausea	Vomit #/24hr	Loose BM #/24hr	Bloody BM #/24hr		