

PATIENT ILLNESS / INFECTION LOG

Patient Name:	Patient Number:
Address:	Phone:
Primary Diagnosis:	Secondary Diagnoses:
Date of Admission on Service:	Assigned Care Team/Geographic Area:
Date of Infection Onset	Today's Date
Symptoms: <input type="checkbox"/> fever ____° F <input type="checkbox"/> productive cough <input type="checkbox"/> drainage (describe) <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> rash (describe) <input type="checkbox"/> other (describe)	
Physician Intervention: <input type="checkbox"/> no <input type="checkbox"/> yes (specify)	
Classification of Infection:	
Source: <input type="checkbox"/> Care Related (CR) <input type="checkbox"/> Non-Care Related (NCR) <input type="checkbox"/> Other	
Infectious Organism, if none:	
Antibiotic Ordered: <input type="checkbox"/> no <input type="checkbox"/> yes, specify	
Prior Health Care Setting Informed, as appropriate: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> NA	
Pertinent Information Shared:	
Name of contact: _____ Date: _____	
For Care Related: # of caregivers from organization _____ # of informal caregivers _____	
Pertinent Information:	
Signature of person completing this report _____	
Follow up:	
Signature of person conducting follow up _____	