

# INDIVIDUAL RESIDENT INFECTION SURVEILLANCE REPORT

DATE	PHYSICIAN		
ROOM NO.      MR NO.	RESIDENT		
ADMIT DATE	DISCHARGE DATE	EXPIRED	
DATE SYMPTOMS DEVELOPED	TPR		
LIST SYMPTOMS			
TYPE OF INFECTION	URI	UTI	SKIN
	WOUND	EYE	OTHER _____
CULTURE	Yes	No	
ORGANISM	(1) _____		(2) _____
A. If UTI:	Bacteria Count	_____	
	Foley	Yes	No
B. If UTI:	Results	_____	
	Chest X-Ray	Yes	No
MEDICATION			
PRECAUTIONS/ISOLATION (type)			
DATE INFECTION CLEARED			
INFECTION PRESENT AT ADMISSION	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
INFECTION DEVELOPED AFTER ADMISSION	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
REPORTED TO INFECTION CONTROL COMMITTEE	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
NURSE SIGNATURE			