GASTROENTERITIS LINE LIST FORM

Facility Name_____

Contact Person_____Email_____

Case initials	Pt. Location		Symptom onset date	Fever Y/N/U	T max °	Nausea Y/N/U	Vomiting Y/N/U	Diarrhea Y/N/U	Abdominal Cramps Y/N/U	Severity						Treatment		Lab Testing Lab Name(if testing done)_____				
	Unit	Room #								Duration	Physician Seen Y/N/U	Hospitalized Y/N/U	Hospital Name (if hosp)	Died Y/N/U	Date of Death	Antibiotic Y/N/U	Antidiarrheal Medication Y/N/U	Y/N/U	Specimen Type	Collect Date	Type of test	Result

BCDC GI Illness Line List Form
March 2004
DRAFT

*ND = not done