

INFECTION SURVEILLANCE – GASTROINTESTINAL TRACT INFECTION

RESIDENT NAME _____ MEDICAL REC. # _____

UNIT _____ ROOM # _____

DATE INFECTION WAS NOTED _____ ADMISSION DATE _____

◆ GASTROINTESTINAL TRACT INFECTION (CHECK BOXES ONLY AFTER CRITERIA HAVE BEEN MET)

INFECTION/SITE	CRITERIA	CONDITIONS & COMMENTS
<input type="checkbox"/> Gastroenteritis	<p>MUST HAVE at least 1 of the following:</p> <p><input type="checkbox"/> 2 or more loose or watery stools above what is normal for resident within a 24-hr period</p> <p><input type="checkbox"/> 2 or more episodes of vomiting within a 24-hr period</p> <p><input type="checkbox"/> BOTH of the following:</p> <p style="padding-left: 20px;"><input type="checkbox"/> stool culture positive for a pathogen (salmonella, sigella, E. coli O157:H7, campylobacter) or toxin assay positive for c. difficile toxin, AND</p> <p style="padding-left: 20px;"><input type="checkbox"/> at least 1 of the following: nausea, vomiting, diarrhea, abdominal pain or tenderness</p>	<p>Care must be taken to rule out noninfectious cause of symptoms. For instance, new medication may cause both diarrhea and vomiting.</p>

Antibiotics Ordered: Yes No

List Antibiotics Ordered:

Signature of person preparing this form: _____