LOG OF RESIDENTS WITH ACUTE GASTROINTESTINAL ILLNESS

FACILITY_____ **DATE**_____

Patient Identification			Patient Location		Description of Illness Please Describe or answer Yes/No								Medications		Comments Lab Tests Illness Outcomes
Name	Age	Sex M/F	Unit	Room #	Onset Date	Highest Temp	Vomiting Projectile	Nausea	Diarrhea (Watery, Bloody)	Abd Cramps	Chills	Date Symptoms Stopped	Antiemetic Start	Antibiotic Start	