

Record of Infectious Outbreak: D&V – Patient information

Unit: Tel:	Date IPCN informed:	Date closed:	Date opened:
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E-mail completed form to IPC Team – [REDACTED] (to mark boxes double click and click on checked)

Patient name and NHS number	Admission date	Date of onset symptoms	Date of last symptoms	Bay/ Room No.	Laxatives/Antibiotics/NG feed/Surgery /other potential causative factor	Comments	Date/time stool specimen sent	D	V
1							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ICPG1 SECTION 4 – COMMUNICABLE DISEASES AND OUTBREAK CONTROL
Appendix 2 (October 2020)

Patient name and NHS number	Admission date	Date of onset symptoms	Date of last symptoms	Bay/room	Laxatives/Antibiotics/NG feed/Surgery/other potential causative factor	Comments	Date/time stool specimen sent	D	V
6							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10							Date: Time: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>