

Acute Gastrointestinal Illness Survey Form

Please fax the completed form to HEIC at 4-0888

Date completed _____ Form completed by _____

How can we reach you? _____

Name: _____ Age: _____ Sex: _____

Patient Yes No Healthcare worker Yes No

If Healthcare worker- type of Work: Nurse Clerical Associate Physician Student
 Other _____ not applicable

Specify Shift: _____ Unit/ Area _____

Do you work in any other facilities? Good Samaritan Bayview other _____

If patient, Date admitted _____, Unit _____

If patient were symptoms present on admission Yes No

Please check if you/patient have or had any of these symptoms:

	Yes	No	Onset (date)	Duration (days)
Diarrhea	___	___	_____	_____
Vomiting	___	___	_____	_____
Abdominal cramps	___	___	_____	_____
Nausea	___	___	_____	_____
Fever	___	___	_____	_____
Blood in stool	___	___	_____	_____
Headache	___	___	_____	_____
Chills	___	___	_____	_____
Muscle ache	___	___	_____	_____
Diaphoresis	___	___	_____	_____
Other	___	___	_____	_____

Did you have any exposure to acute GI illness? Healthcare worker Patient Family /friend

If so list symptoms _____ Date _____

Where _____

Were you hospitalized for this problem? Yes _____ No _____

If see by a physician or hospitalized, was a stool culture taken? Yes ___ No ___

Did you work with symptoms? Yes _____ No _____ if so list unit _____

Date worked _____

Comments: _____

Thank you for your help.