Submit completed form daily to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_via email ([xxxxxxx@xxxxx.xxx](mailto:xxxxxxx@xxxxx.xxx)), phone (xxx/xxx.xxxx) or fax (xxx/xxx.xxxx)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Part III** | | **Persons SEEN OR TREATED** | | |
| **TOTAL SEEN OR TREATED DURING CURRENT REPORTING PERIOD:** | | | | **#** |
|  | **RACE / ETHNICITY** | | White | **#** |
| Black/African American | **#** |
| Hispanic or Latino | **#** |
| Asian | **#** |
| Unknown | **#** |
| **age** | | ≤ 1 years | **#** |
| ≥ 65 years | **#** |
| Pregnant females | | | | **#** |
| **TOTAL REFERRED TO HOSPITAL:** | | | | **#** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Part I** | | | | | | **FACILITY Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LOCATION: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  | | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | | | | | | | |  |
| STATE zIPCODE NAME OF FACILITY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REPORTING PERSON/CONTACT: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | | | |  |
|  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |
| PHONE NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | | | |  |
|  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |
| FAX EMAIL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Part II** | | | | | | **REPORTING PERIOD** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| START: | | | |  | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | | AM PM | |
|  | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| END: | | | |  | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | AM PM | | |
|  | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
| MONTH DAY YEAR HOUR (CIRCLE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TOTAL SHELTER POPULATION AT START:** | | | | | | | | | | | | | | | | | | | | | | | | | | | **#** | | | | | | | |

|  |  |
| --- | --- |
| **Part IV** | **TREATED PATIENTS**  Use categories that best describe patients’ **current** reasons forseeking care. Complete the **Total** patient tallies for each syndrome category in the column to the right. Be as specific as possible. A single patient may be counted more than once. |

|  |  |
| --- | --- |
| **SYNDROME CATEGORY** | **TOTAL** |
| **WORKERS/VOLUNTEERS - TOTAL** | **\_\_ \_\_ \_\_** |
| **INJURY - TOTAL** | **\_\_ \_\_ \_\_** |
| Fall, slip, trip (from height or same level) | **\_\_ \_\_ \_\_** |
| Motor vehicle crash | **\_\_ \_\_ \_\_** |
| Carbon monoxide exposure | **\_\_ \_\_ \_\_** |
| Violence/assault | **\_\_ \_\_ \_\_** |
| Injury - not specified above | **\_\_ \_\_ \_\_** |
| **DERMATOLOGIC/SKIN - TOTAL** | **\_\_ \_\_ \_\_** |
| Rash | **\_\_ \_\_ \_\_** |
| Infection | **\_\_ \_\_ \_\_** |
| Infestation (e.g., lice or scabies) | **\_\_ \_\_ \_\_** |
| **GASTROINTESTINAL ILLNESS - TOTAL** | **\_\_ \_\_ \_\_** |
| Diarrhea - bloody | **\_\_ \_\_ \_\_** |
| Diarrhea - watery | **\_\_ \_\_ \_\_** |
| Nausea or vomiting | **\_\_ \_\_ \_\_** |
| **OB/GYN – TOTAL** | **\_\_ \_\_ \_\_** |
| GYN condition not associated with pregnancy or post-partum period | **\_\_ \_\_ \_\_** |
| In labor | **\_\_ \_\_ \_\_** |
| Pregnancy complication | **\_\_ \_\_ \_\_** |
| Routine pregnancy check-up | **\_\_ \_\_ \_\_** |
| **RESPIRATORY ILLNESS - TOTAL** | **\_\_ \_\_ \_\_** |
| Congestion, runny nose, sinusitis | **\_\_ \_\_ \_\_** |
| Cough | **\_\_ \_\_ \_\_** |
| Pneumonia, suspected | **\_\_ \_\_ \_\_** |
| Shortness of breath or difficulty breathing | **\_\_ \_\_ \_\_** |
| Wheezing in chest | **\_\_ \_\_ \_\_** |
| **INFLUENZA-LIKE-ILLNESS (ILI) - TOTAL** | **\_\_ \_\_ \_\_** |

|  |  |
| --- | --- |
| **SYNDROME CATEGORY** | **TOTAL** |
| **OTHER ILLNESS - TOTAL** | **\_\_ \_\_ \_\_** |
| Dehydration | **\_\_ \_\_ \_\_** |
| Fever (≥100o F or 37.8o C) | **\_\_ \_\_ \_\_** |
| Meningitis/encephalitis, suspected | **\_\_ \_\_ \_\_** |
| Neurological | **\_\_ \_\_ \_\_** |
| Pain | **\_\_ \_\_ \_\_** |
| Other illness – not specified above | **\_\_ \_\_ \_\_** |
| **EXACERBATION OF CHRONIC DISEASE - TOTAL** | **\_\_ \_\_ \_\_** |
| Cardiovascular disease (e.g., hypertension, CHF) | **\_\_ \_\_ \_\_** |
| Diabetes | **\_\_ \_\_ \_\_** |
| Immunocompromised (e.g., HIV, lupus) | **\_\_ \_\_ \_\_** |
| Neurological (e.g., seizure, stroke) | **\_\_ \_\_ \_\_** |
| Respiratory (e.g., Asthma, COPD) | **\_\_ \_\_ \_\_** |
| **MENTAL HEALTH - TOTAL** | **\_\_ \_\_ \_\_** |
| Agitated behavior | **\_\_ \_\_ \_\_** |
| Anxiety or stress | **\_\_ \_\_ \_\_** |
| Depressed mood | **\_\_ \_\_ \_\_** |
| Drug/alcohol intoxication or withdrawal | **\_\_ \_\_ \_\_** |
| Previous mental health diagnosis | **\_\_ \_\_ \_\_** |
| Psychotic symptoms (i.e. paranoia) | **\_\_ \_\_ \_\_** |
| Suicidal thoughts or ideation | **\_\_ \_\_ \_\_** |
| **ROUTINE/FOLLOW-UP - TOTAL** | **\_\_ \_\_ \_\_** |
| Medication refill | **\_\_ \_\_ \_\_** |
| Blood sugar check | **\_\_ \_\_ \_\_** |
| Blood pressure check | **\_\_ \_\_ \_\_** |
| Vaccination | **\_\_ \_\_ \_\_** |
| Wound care | **\_\_ \_\_ \_\_** |
| **OTHER REASON FOR VISIT,** not listed above | **\_\_ \_\_ \_\_** |