Health Tracking: Infection Tracking

General Information:

*Individual: _____ Time zone: _____
*Program: _____ *Date: _____
*Entered By: _____ *Reported By: _____

Notification Level: ☐ Low ☐ Medium ☐ High

Infection Tracking Information:

Infection Type (ICD-10) *Code: _____ *Description:_____
_____

Infection Site

*Body Part(s): ☐ Abdomen ☐ Ankle Left ☐ Ankle Right ☐ Arm Left ☐ Arm Right ☐ Back ☐ Buttock Left ☐ Buttock Right ☐ Buttocks ☐ Calf Left ☐ Calf Right ☐ Chest ☐ Ear Left ☐ Ear Right ☐ Elbow Left ☐ Elbow Right ☐ Eye Left ☐ Eye Right ☐ Face ☐ Finger Index Left ☐ Finger Index Right ☐ Finger Little Left ☐ Finger Little Right ☐ Finger Middle Left ☐ Finger Middle Right ☐ Finger Ring Left ☐ Finger Ring Right ☐ Finger Thumb Left ☐ Finger Thumb Right ☐ Fingers Left ☐ Fingers Right ☐ Foot Left ☐ Foot Right ☐ Fore Arm Left ☐ Fore Arm Right ☐ Forehead ☐ Genitals ☐ Hand Left ☐ Hand Right ☐ Head ☐ Hip Left ☐ Hip Right ☐ Internal ☐ Knee Left ☐ Knee Right ☐ Leg Left ☐ Leg Right ☐ Lips ☐ Lower Back ☐ Mouth ☐ Neck ☐ Nose ☐ Rectum ☐ Shin Left ☐ Shin Right ☐ Shoulder Left ☐ Shoulder Right ☐ Systemic ☐ Teeth ☐ Thigh Left ☐ Thigh Right ☐ Throat ☐ Toe 2nd Left ☐ Toe 2nd Right ☐ Toe 3rd Left ☐ Toe 3rd Right ☐ Toe 4th Left ☐ Toe 4th Right ☐ Toe Big Left ☐ Toe Big Right ☐ Toe Left ☐ Toe Little Left ☐ Toe Little Right ☐ Toe Right ☐ Tongue ☐ Upper Arm Left ☐ Upper Arm Right ☐ Upper Back ☐ Waist ☐ Wrist Left ☐ Wrist Right
If Other: _____

Medication History
Name: _____
Strength: _____ Give Amount / Quantity: _____
Frequency: _____ Route: _____

Date Onset: _____ Date of Resolution: _____

Hospitalization: ☐ Yes ☐ No

Comments:_____
_____
_____
_____
_____

SIGNATURE ..... **NAME** ..... **DATE** ..... **TIME** ..... am/pm
Note: Required fields are marked with an asterisk (*)