RESIDENTS BY LOCATION FORM

Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

Section A: for all residents on the day of the survey				Section B: only complete if response to 4 = Y For 8 to 18 Write **Y** if the condition is TRUE ON THE DAY OF THE SURVEY																Section C: To be completed by NH Team Lead or EIP Team		
CDC Resident ID	FOR LOCAL USE, WILL NOT BE TRANSMITTED TO CDC Room, bed number	Resident name	Admission date, mm/dd/yyyy	Present in the facility	Age in years	Race	Ethnicity	Male gender	Short stay	Diabetes	Receiving dialysis	Wheelchair bound or bedridden	INDWELLING urinary catheter (Foley)	Use of other urinary device (not a Foley)	Central line	Tracheostomy tube	Ventilator	Percutaneous Gastrostomy/ Jejunostomy (PEG/PEJ) tube	Pressure ulcer	Receiving wound care	Receiving systemic antimicrobial(s)	Condition that *may* indicate presence of infection	If 20a = Y, condition(s) present
	1	2	3	4	5	6a	6b	7	8	9	10	11	12a	12b	13	14	15	16	17	18	19	20a	20b
XX-XX-001																							
XX-XX-002																							
XX-XX-003																							
XX-XX-004																							
XX-XX-005																							
XX-XX-006																							
XX-XX-007																							
XX-XX-008																							
XX-XX-009																							
XX-XX-010																							

6a. Race response options: **A**merican Indian or Alaska Native, **As**ian, **B**lack or African American, **N**ative Hawaiian/Other Pacific Islander, **W**hite
6b. Ethnicity response options: **H**ispanic/Latino , **No**t Hispanic/Latino
20b. Only complete if 20a=Y. Use the instructions to indicate which conditions are present

FACILITY ID: ____- ____ SURVEY DATE: _____ DATA COLLECTORS INITIALS: _____

LOCATION NAME: _____ LOCATION TYPE: _____ TOTAL BEDS (OCCUPIED + NON-OCCUPIED): _____