

## 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		Admission date, mm/dd/yyyy	Present in the facility	Age in years	Race	Ethnicity	Male gender	Short stay	Diabetes	Receiving dialysis	Wheelchair bound or handicapped	INDWELLING urinary catheter (Foley)	Use of other urinary device (not a Foley)	Central line	Tracheostomy tube	Ventilator	Percutaneous Gastrostomy/leaving tube (PEG/DELT) tube	Pressure ulcer	Receiving wound care	Receiving systemic antimicrobial(s)	Condition that may indicate presence of infection	If 20a = Y, condition(s) present
	Room, bed number	Resident name																					
	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: <u>A</u> merican Indian or Alaska Native, <u>A</u> asian, <u>B</u> lack or African American, <u>N</u> ative Hawaiian/Other Pacific Islander, <u>W</u> hite 6b. Ethnicity response options: <u>H</u> ispanic/Latino, <u>N</u> ot Hispanic/Latino 20b. Only complete if 20a=Y. Use the instructions to indicate which conditions are present																							
Public reporting burden of this collection of information is estimated to average 15 minutes per response (one row) or 150 minutes for all 10 rows, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).																							

FACILITY ID: \_\_\_\_\_ - \_\_\_\_\_

SURVEY DATE: \_\_\_\_\_

DATA COLLECTORS INITIALS: \_\_\_\_\_

LOCATION NAME: \_\_\_\_\_

LOCATION TYPE: \_\_\_\_\_

TOTAL BEDS (OCCUPIED + NON-OCCUPIED): \_\_\_\_\_