Facility: Month & Year:

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| **Rm. #** | **Resident Name** | **Admit Date** | **Onset Date** | **Urine** | **Respiratory** | **Skin** | **Ear/Eye** | **Blood** | **GI** | **Other** | **R/M/P\*** | **I.P.S. (i.e., F/C)** | **Fever** | **Sign & Symptoms** | **Mental Status**  **(Change?)** | **Organism on**  **Culture** | **X-Ray (+/-)** | **Treatment** | **CAI** | **HAI** | **Does NOT meet Criteria \*** | **COMMENT** |
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