APPENDIX J

FACILITY NAME

SCABIES CASE/CONTACT LINELIST FORM: PATIENT/RESIDENT

IP Name: _____ Contact Person: _____

Date: _____

Patient Information								Patient Location		Illness Description						
Name	MRN	Age	Sex	Admit date	Discharge date / To Where	Admission Dx	Exposure Dates	Room # / Unit & Location	Unit / Bed after Exposure	Onset Date	Evaluated for Scabies	Skin Scraping (Y/N)	Scabies Sign Sx	Number of Scabies Tx	Scabies Tx Name	Scabies Tx Date(s)