B-14.26 Attachment A

CORRECTIONAL MANAGED HEALTH CARE
GASTROINTESTINAL ILLNESS
OFFENDER PATIENT REPORT

Unit Name _____

Report for new-onset (not cumulative) patients for 24-hour period beginning 6AM_____/_____/_____to 6AM_____/_____/_____

Date sent_____/_____/_____

	Patient Name (Last, First)	TDCJ #	Housing Location (e.g. dorm, cell block, pod)**	Bed Location**	Work Assignment**	Onset	Symptoms			Meds Prescribed
						Date (___/___/___)	Nausea or Vomiting (X)	Diarrhea (X)	Housing Location after exam	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										

Fax: 936-437-3572 ****at onset of symptoms**

Subject line: Unit name, Gastro log, and Date sent

Revised 8/18