Appendix V

LINE LIST FORM — EMERGENCY DEPARTMENT

DATE _____
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#	Date of Visit	Patient Name	Patient ID# (check one)	Isolation Precautions Initiated/Type	SIGNS AND SYMPTOMS				Patient Sent to:
					Symptom (√)	Symptom (√) Other (specify)	Diagnostic tests done? (specify)	Treatment given? (specify)	
			☐MRN ☐Disaster Response #	A = Airborne C = Contact D = Droplet	N = Nausea V = Vomiting F = Fever D = Diarrhea				A = Admitted D = Discharged Home I = Admitted to negative pressure room M = Morgue N = Nursing Home O = Other T = Transfer to other site
1.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
2.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
3.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
4.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
5.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
6.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
7.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
8.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
9.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
10.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
11.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
12.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
13.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
14.				☐A ☐C ☐D	☐N ☐V ☐F☐D				
15.				☐A ☐C ☐D	☐N ☐V ☐F☐D				