Facility: **Date:**

Line List for COVID-19 - RESIDENTS

Identification				Resident Location		Onset	Signs and Symptoms												Illness Outcome				
Name	D.O.B.	Age	Gender	Resident's Wing	Resident's Room #	Date of Onset	Dry Cough	Productive Cough	Shortness of Breath	New Olfactory or Taste Disorder	Fever/Chills/Rigors	Muscle Aches/Myalgia	Headache	Sore Throat	Nausea/Vomiting	Diarrhea	Fatigue	Congestion/Runny Nose	Vaccinated	Visited ER	Died	Days Hospitalized	Duration of Illness in Hours
Last, First	MM/DD/YYYY	Years	(M/F)		RM#	MM/DD/YYYY	(Y - Yes; N - No; U- Unknown)															Days	Days