

Appendix B – Patient/Resident (Symptomatic) Line Listing for Scabies

DATE: _____ SITE/FACILITY/UNIT: _____ PHONE #: _____

If no addressograph, please include:		<i>Addressograph</i>	<i>Addressograph</i>	<i>Addressograph</i>
Full Name PHN DOB Physician				
Room #				
Onset Date and Time				
Diagnosed (By Who/When)				
Isolation Yes/No				
SYMPTOMS	Symmetrical skin eruptions			
	Wavy lines (about 1" long)			
	Itching			
	Flaky, scaly skin			
	Dots surrounded by redness/streaks			
	Rash - list location(s)			
	Rash face/scalp (Peds)			
	New/undiagnosed rash			
	Rash hand/feet (Peds)			
Other (Specify)				
RX started				
2 nd Treatment (as applicable)				
Update and Comments				