

Surveillance date mm yyyy
 ____/____

Facility name: ----- Code -----

Denominators for Specialty Care Area (SCA)/Oncology (ONC)

Location: location code: Number of patients remaining from the previous month:.....
(for Oncology ICU only)

Date	Number of new arrivals (for Oncology ICU only)	Number of patients	Number of patients with one or more central lines (if patient has both, count as Temporary)		Number of patients with a urinary catheter	Number of patients on a ventilator
			Temporary	Permanent		
1						
2						
3						
4						
5						
6						
7						
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21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
Total						
	New patients	Patient-days	Temporary CL-days	Permanent CL-days	Urinary catheter-days	Ventilator-days

Doctor's Signature -----

Nurse's Signature-----