Case Definition:

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## CHITDDEAK LINE LICTING DECIDENTS

| * <b>FAX to:</b> 905-974-9847 (DO NOT EMAIL) | OUTBREAK LINE LISTING - RESIDENTS | ☐ Enteric |
|----------------------------------------------|-----------------------------------|-----------|
| Outbreak Number:Outbreak location (unit)     | Facility Name/ Ac                 |           |

| Please print legibly or type            |                                 |                        |                         | Symptoms             |                     |                        |             |        |          | S        | Vaccine                                                                                                                     | Treatment       | eatment S                        |           | ;                       | S          | tatus               |                    |                |
|-----------------------------------------|---------------------------------|------------------------|-------------------------|----------------------|---------------------|------------------------|-------------|--------|----------|----------|-----------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------|-----------|-------------------------|------------|---------------------|--------------------|----------------|
| Resident's Legal Name  DOB YYYY /MM/ DD | Room Meets Case Definition? Y/N | Onset<br>Date<br>(d/m) | Fever (37.8 or greater) | New /worsening cough | Shortness of breath | Loss of taste or smell | Sore throat | Nausea | Vomiting | Diarrhea | Other  (headache, runny nose/nasal congestion, unexplained malaise/fatigue, chills, conjunctivitis, loss of appetite, etc.) | Influenza (Y/N) | Receiving<br>Antivirals<br>(Y/N) | Test Type | Date Collected<br>(d/m) | Lab Result | Resolved Date (d/m) | Hospitalized (d/m) | Deceased (d/m) |
|                                         |                                 |                        |                         |                      |                     |                        |             |        |          |          |                                                                                                                             |                 |                                  |           |                         |            |                     |                    |                |
|                                         |                                 |                        |                         |                      |                     |                        |             |        |          |          |                                                                                                                             |                 |                                  |           |                         |            |                     | <u> </u>           |                |
|                                         |                                 |                        |                         |                      |                     |                        |             |        |          |          |                                                                                                                             |                 |                                  |           |                         |            |                     | <u> </u>           |                |
|                                         |                                 |                        |                         |                      |                     |                        |             |        |          |          |                                                                                                                             |                 |                                  |           |                         |            |                     | <u> </u>           |                |
|                                         |                                 |                        |                         |                      |                     |                        |             |        |          |          |                                                                                                                             |                 |                                  |           |                         |            |                     | <u> </u>           |                |
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## **OUTBREAK LINE LISTING – STAFF**

| Outbreak Number:         | Facility Name/ Address |  |
|--------------------------|------------------------|--|
| Outbreak location (unit) | Facility Contact:      |  |
| Case Definition:         | •                      |  |

| Please print legibly or type |                       |                                         |                                                             |                            |                        |                                | Symptoms                |                      |                     |                        |             |        |          | Vaccine  |       | Specimen        | S         | Status                     |            |                     |
|------------------------------|-----------------------|-----------------------------------------|-------------------------------------------------------------|----------------------------|------------------------|--------------------------------|-------------------------|----------------------|---------------------|------------------------|-------------|--------|----------|----------|-------|-----------------|-----------|----------------------------|------------|---------------------|
| Staff's Legal Name           | DOB<br>YYYY-<br>MM-DD | Position<br>i.e. RN,<br>PSW,<br>Dietary | Location of<br>duties<br>i.e. unit/floor,<br>whole facility | Meets Case Definition? Y/N | Onset<br>Date<br>(d/m) | Last<br>Day<br>Worked<br>(d/m) | Fever (37.8 or greater) | New /worsening cough | Shortness of breath | Loss of taste or smell | Sore throat | Nausea | Vomiting | Diarrhea | Other | Influenza (Y/N) | Test Type | Date<br>Collected<br>(d/m) | Lab Result | Resolved Date (d/m) |
|                              |                       |                                         |                                                             |                            |                        |                                |                         |                      |                     |                        |             |        |          |          |       |                 |           |                            |            |                     |
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