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RESPIRATORY OUTBREAK LINE LISTING FORM

CHECK ONE ONLY: ☐ STAFF DATA ☐ RESIDENT DATA

Number at Risk: _____ _____

INSTITUTIONAL NAME: _____

OUTBREAK NUMBER: _____

Telephone: _____

Fax: _____

CASE DEFINITION: _____

Contact Person: _____

Case Identification				**Symptoms**														**Complications**				**Specimens / Diagnostics**						**Prophylaxis / Treatment**		
Case Number (sequentially)	Name & Location (floor, room)	Gender (M/F)	Age	Onset date of first symptom (d/m)	Abnormal temperature (°C)	Dry cough (new)	Productive cough (new)	Runny nose / sneezing	Nasal congestion / stuffy nose	Chest congestion	Sore throat	Hoarseness / difficult swallowing	Chills	Myalgia (muscle ache)	Malaise, lethargy	Headache	Poor / loss of appetite	Other - please specify (SOB*, decreased mental status)	Bronchitis (date d/m)	Pneumonia (date d/m)	Hospitalization (date d/m)	Death (date d/m)	Nasopharyngeal (date d/m)	Result (date d/m)	x-ray conf. Pneumonia (Y/N)	Result date (d/m)	Other – specify (date d/m)	Result date (d/m)	Antivirals (date d/m) Type ____	Flu Vaccine (date d/m)	Antibiotic (date d/m)

* SOB (new or increased shortness of breath)