Outbreak - Respiratory Line List - Resident (SVC-ID) Outbreak Number 2 2 3 3 - 2 0 _ _ - _ _ _

Facility: _____ Unit: _____ Date declared: _____

Telephone: _____ Total Residents in Unit: _____

Facility Contact Person: _____ Total Residents in Facility: _____

Alternate Contact Person: _____ Pathogen: _____ Date identified: _____

Fax Daily to Grey Bruce Health Unit: 519-376-4152

Case Information				Symptoms														Diagnosis				Prophylaxis / Treatment				Hosp.		Outcomes	
Name	Room #	Received **Flu Vaccine** (Y/N)	# **COVID-19 Vaccine** doses	**Date of Onset**	Abnormal Temperature / fever	Chills	Cough (dry or productive)	Shortness of Breath	Sore throat / Hoarseness / Difficulty Swallowing	Runny Nose / sneezing / Nasal Congestion	Olfactory or Taste Disorder (new)	Nausea / Vomiting	Diarrhea	Myalgia (muscle pain)	Fatigue / Malaise	Headache	*Other	None	Pneumonia (C-Clinical / R-Radiography)	Rapid Antigen Test (date, + / -)	NP Swab Collected (date)	COVID Results (+ / -)	**Flu Antiviral Prophylaxis** (date)	**Flu Antiviral Treatment** (date)	**COVID Antiviral Treatment** (date)	Antibiotic	Date **Admitted**	Date **Discharged**	**Deceased (date)**	Date Out of Isolation