

Outbreak - Respiratory Line List - Staff (SVC-ID)

Outbreak Number **2 2 3 3 - 2 0** _ _ _ - _ _ _



Facility: _____

Unit: _____ Date declared: _____

Telephone: _____

Total staff in Unit: _____

Facility Contact Person: _____

Total Staff with Facility: _____

Alternate Contact Person: _____

Pathogen: _____ Date identified: _____

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

Case Information					Symptoms											Diagnosis / Prophylaxis				Outcomes						
Name	Department	Last day worked	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	Rapid Antigen Test (date, + / -)	NP Swab Collected (date)	COVID Results (+ / -)	Flu Antiviral Prophylaxis (date)	Date of Last Symptom	Return to Work Date	