

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



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	