

Data Collection for Long Term Care and Residential Care Facility for Respiratory Outbreaks

Date of report: _____ Name of Epi Notified: _____

Name of person reporting outbreak: _____ Contact number: _____

Role of the reporting person: _____ Email: _____ Fax: _____

Preferred method of receiving resource packet: Email Fax

Facility Name: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: (____) _____ - _____

Summary of staff (e.g., non-healthcare workers and healthcare workers) and non-staff (e.g., residents or patients) at the facility:

Number of staff: _____ + Number non-staff: _____ = Total number at the facility: _____

Number of staff ill: _____ + Number non-staff ill: _____ = Total number ill at the facility: _____

Date of onset for first ill person: _____

Are people still currently ill? Yes No Unk

If no, date of onset for last ill person: _____

What symptoms are being reported? Fever Cough Sore throat Myalgias Pneumonia

Other symptoms of note: _____

Has any flu testing been done on ill residents or staff? Yes No Unk

If yes, what type of testing? Rapid PCR Viral Culture

If yes, have any residents or staff tested positive for flu? Yes No Unk

If yes, what type of flu have residents or staff tested positive? Flu A Flu B

Were residents and staff encouraged to receive the flu vaccine at the start of this flu season? Yes No

If flu vaccine was offered to residents and staff, what type of flu vaccine was offered? Regular trivalent

Regular quadrivalent High-dose trivalent

Were the ill persons vaccinated against flu? Yes No Unk

Is there a recognized clustering of ill persons or a known connection between them (e.g., roommates, residents in the same hall, dining partners, social acquaintances)? Yes No Unk

If yes, please describe: _____