Facility Outbreak Line List

Fax line lists daily by **10:00 AM** to **519-977-5097** until outbreak declared over by the WECHU.

Phone: 519-258-2146 ext. 2264
After Hours: 519-973-4510

Facility Name: ____

Facility Address: ____

Facility Phone and Ext: ____

Contact Person #1: ____

Contact Person #2: ____

Select ONLY one:
- ☐ **Respiratory**
- ☐ **Enteric**

Select ONLY one:
- ☐ **Resident**
- ☐ **Patient**
- ☐ **Children**
- ☐ **Staff**

Line List Outbreak # 2268-________________

Index Case Symptom Onset Date: YYYY-MM-DD ________________________

Control Measures Started Date: YYYY-MM-DD ________________________

Submission Date: YYYY-MM-DD ________________________

Submitted By: ________________________

Respiratory

Submit line list when:

[1] Two or more cases of acute respiratory infections occur within 48hrs with a common epi-link (e.g., Unit, floor) in residents. ***OR***
[2] One or more laboratory-confirmed case(s) of influenza in a resident. ***OR***
[3] One or more positive tests for Covid-19 in residents. ***OR***
[4] Directed by WECHU

Enteric

Submit line list when 2 or more people have:

[1] Two or more episodes of diarrhea (e.g., loose/watery bowel movements) within a 24-hour period, ***OR***
[2] Two or more episodes of vomiting within a 24-hour period, ***OR***
[3] One or more episodes of diarrhea *AND* one or more episodes of vomiting within a 24-hour period

Case Definition

Check all as defined by **WECHU:**

- ☐ **Fever**(≥37.8°C)
- ☐ **Headache**
- ☐ **Malaise/Fatigue**
- ☐ **New Cough**
- ☐ **Nausea/Vomiting**
- ☐ **Diarrhea**
- ☐ **Shortness of Breath**
- ☐ **Muscle Aches**
- ☐ **Sore throat/ Hoarseness**
- ☐ **Nasal Congestion/ Sneezing**
- ☐ **Loss of taste/smell**
- ☐ **Other:** ________________________

Case Demographics			Isolation	Symptoms (new or worsening)											Specimens Diagnostics		Vaccination/Treatment				Complications/Outcome				
Case Name (Last, First)	**Date of Birth** YYYY-MM-DD	**Unit/Room #** (resident) OR **Unit Worked/Role** (Staff)	**Isolation & additional precaution start date** or **date of last shift.** MM-DD	Symptom onset date MM-DD	Fever/Abnormal Temp (Celsius)	New/worsening cough	Shortness of Breath	Hoarseness/Sore Throat	Runny Nose/Nasal Congestion	Headache	Fatigue/Malaise/Myalgias	Loss of taste/smell	Vomiting # of episodes	Diarrhea # of episodes **	Specimen Collection Date MM-DD	Type of Test & Result (+ or -) (RAT, PCR, MRVP, NAAT, Stool)	Covid-19 Vaccine (# of doses)	Influenza Vaccine MM-DD	Antiviral Treatment MM-DD	Antibiotic Treatment MM-DD	**Clinical/X-RAY evidence of pneumonia MM-DD**	Hospitalization Date MM-DD	Hospital Discharge Date MM-DD	**Death MM-DD**	Out of Isolation OR Return to Work Date MM-DD
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**If resident is experiencing new onset of diarrhea, collect stool sample using enteric outbreak stool kit for viral and bacterial testing.

WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

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