

Reporting Facility Name and License Number:
Date Outbreak Identified:

Estimated # of exposed: Patients _____ Staff _____

Patient/staff identifier	Patient Room Number	Unit	If staff, role †	Age	Sex	Onset date	Duration of illness (days)	Fever (Y or N)	(If Fever) Highest temp	Cough (Y or N)	Sore throat (Y or N)	Pneumonia (Y or N)	Other symptoms **	Chest X-ray (+, -, or NA)	Type of test ordered ‡	Pathogen detected	Current Respiratory vaccinations*	Antiviral treatment (date started)	Hospitalized (Y or N)	Died (Y or N)	Resolved (Y or N)

† Staff Role: P=Patient care, F=Food service, H=Housekeeping, M=Maintenance, A=Administrative/clerical, O=Other
‡ Test Type: 0=No test, 1=Culture, 2= PCR, 3=Rapid test, 4=Other (specify)
* Respiratory Vaccinations: Y=ALL, N=None, Unk=Unknown, F = Flu, C = Covid, R = RSV, P = Pneumovax
** Other symptoms: H=Headache, CO=Congestion, RN=Runny nose, GI=Gastrointestinal symptoms, N=Nausea, SB=Shortness of breath, LA=Loss of appetite, CH=Chills, M=Myalgia, O=Other (specify)