

Public Health Laboratory - Outbreak Notification Report

Instructions:

1. Complete Entire Form.
2. Notify your local PHL by telephone (during business hours 8 a.m.-5p.m.). (PHL Helpdesk: Telephone 1-800-640-7221).
3. FAX to your local Public Health Laboratory (PHL-Toronto Fax: 416-235-6103).
4. For further information and after-hours instructions see Labstract "Outbreak Notification and Specimen Submission Procedures" at www.oahpp.ca

Initial Notification
 Update
 Final (Closed)
 Respiratory
 Enteric
 Food borne illness
 other

FROM:

Health Unit/Institution _____

()

Contact Person _____

Title _____

Telephone _____

EPIDEMIOLOGICAL DATA

PREDOMINANT CLINICAL FEATURES

<p>Outbreak Coordinator: _____ Telephone () _____</p> <p>Health Unit Outbreak No: _____ (Health Unit # / YYYY / Outbreak #)</p> <p>Location of Outbreak: Name of Institution/Event/Source _____</p> <p>Address: _____</p> <p>Postal Code: _____</p> <p>Date of Onset _____ (Index Case): (YYYY/MM/DD): _____</p> <p>No. of Residents/persons: ill: _____ at risk/exposed: _____ hospitalized: _____</p> <p>Number of Fatal Cases: _____</p>	<p>Respiratory symptoms</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Flu-like Symptoms</p> <p>Respiratory Congestion</p> <p><input type="checkbox"/> URT <input type="checkbox"/> LRT</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Myalgia</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Other (specify) _____</p>	<p>Enteric symptoms</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Abdominal Cramps</p> <p>Diarrhea</p> <p><input type="checkbox"/> Watery Diarrhea</p> <p><input type="checkbox"/> Bloody Diarrhea</p> <p><input type="checkbox"/> Dehydration</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Other (specify) _____</p>
<p>Incubation Period: (hours/days) Median: _____ Range: _____</p>		<p>Duration of Illness: (hours/days) Median: _____ Range: _____</p>
<p>Travel History: _____</p>		

Suspected Etiological Agents: _____

Facility Type/ OB Location:

- | | | | | |
|--|--|--|--|-----------------------------------|
| <input type="checkbox"/> Camp | <input type="checkbox"/> Clinic | <input type="checkbox"/> Community/ Family Gathering (specify) _____ | <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Day Care |
| <input type="checkbox"/> Food Supplier/Distributor | <input type="checkbox"/> Hospital | <input type="checkbox"/> Long-Term Care Home | <input type="checkbox"/> Military Base | |
| <input type="checkbox"/> Psychiatric Hospital | <input type="checkbox"/> Restaurant/ Eatery | <input type="checkbox"/> Retirement Home / Seniors' Residence | | |
| <input type="checkbox"/> School | <input type="checkbox"/> Other (Specify) _____ | | | |

Shaded area for laboratory use only

Notification Received By: _____ Telephone: () _____
 Name

Dept/Sec: _____ PHL: _____ Date: _____ Time: _____ am/pm

Notes: _____ (YYYY/MM/DD)