Gastrointesinal Illness Outbreak: Summary Form

(For Facility/School Use Only)

Fax completed form to **401-222-2488** ATTN: _____. If you have any questions, call 401-222-2577

Please complete this form at the start **and** at the end of the outbreak (The outbreak can be considered over 4 days after the last identified case had his/her initial onset of nausea, vomiting and/or diarrhea.)

NOTE: Immediately check for any ill food handlers. All ill food handlers and direct care staff **MUST** be sent home immediately and should not return for 48 hours after the last episode of nausea, vomiting and/or diarrhea.

BASIC INFORMATION

Date:		**Contact Name:**
Facility Name:		**Phone Number:**
Address:		**Fax Number:**
City:	**Zip:**	**Email:**

Type of Facility: ◯ Nursing Facility (Type: _____) ◯ Rehabilitation Facility ◯ Hospital ◯ School (Grades Range:_____) ◯ Other: _____

OUTBREAK INFORMATION

Illness Onset Date of First Case: **Illness Onset Date of Last Case:**

Specimens Submitted: ◯ Yes ◯ No **If Yes, number submitted:** ____ **If yes, number positive:** ____

Number Visiting Their Medical Provider: ____ **Number of Hospitalizations:** ____

Number Visiting ER/Urgent Care: ____ **Number of Deaths:** ____

	Residents/Students	Staff
Total Number in Each Category (Denominator)		
Total Number of Ill Individuals		
Sex of Ill Individuals		
Male		
Female		
Age of Ill Individuals		
< 1		
1 - 4		
5 - 9		
10 - 19		
20 - 49		
50 - 74		
75 and over		
Symptoms of Ill Individuals		
Vomiting		
Diarrhea		
Nausea		
Fever		
Abdominal Cramps		
Headache		
Other:		

ADDITIONAL NOROVIRUS INFORMATION: Go to http://www.health.ri.gov/diseases/food/?parm=73

Cumulative Gastrointestinal Illness Outbreak Line List for STAFF

Please fax completed form to **401-222-2488** ATTN: ______________________________

Date:		**Contact Name:**
Facility Name:		**Phone Number:**
Address:		**Fax Number:**
City:	**Zip:**	**Email:**

Employee Name	Sex (M/F)	Age	Floor/ Unit Worked	SYMPTOMS		Date of Illness Onset	Date of End of Illnes	Stool Specimen Collected (Circle Y/N; if Y, circle result)	Medical Care Required (Circle Y/N; if Y, circle type: Provider Visit, ER/Urgent Care, Hospital)	Died? (Y/N; if yes, date)	Comments
				Circle the symptom V: Vomit D: Diarrhea N: Nausea F: Fever	Other (Write in Symptom)						
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	

Please add cases until the linelist is full. Update case information as necessary.

Facility Name: ________________________________

Staff Line List
(Gastrointestinal)

Date: ____________

Employee Name	Sex (M/F)	Age	Floor/ Unit Worked	SYMPTOMS: Circle the symptom V: Vomit D: Diarrhea N: Nausea F: Fever	SYMPTOMS: Other (Write in Symptom)	Date of Illness Onset	Date of End of Illnes	Stool Specimen Collected (Circle Y/N; if Y, circle result)	Medical Care Required (Circle Y/N; if Y, circle type: Provider Visit, ER/Urgent Care, Hospital)	Died? (Y/N; if yes, date)	Comments
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	

Please add cases until the linelist is full. Update case information as necessary.

Cumulative Gastrointestinal Illness Outbreak Line List for <u>RESIDENTS / STUDENTS</u>

Please fax completed form to **401-222-2488** ATTN: ______________________________

Date:	**Contact Name:**
Facility Name:	**Phone Number:**
Address:	**Fax Number:**
City: **Zip:**	**Email:**

Resident Name	Sex (M/F)	Age	Floor & Room	SYMPTOMS: Circle the symptom V: Vomit D: Diarrhea N: Nausea F: Fever	SYMPTOMS: Other (Write in Symptom)	Date of Illness Onset	Date of End of Illnes	Stool Specimen Collected (Circle Y/N; if Y, circle result)	Medical Care Required (Circle Y/N; if Y, circle type: Provider Visit, ER/Urgent Care, Hospitalization)	Died? (Y/N; if yes, date)	Comments
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	

Please add cases until the linelist is full. Update case information as necessary.

Division of Preparedness, Response, Infectious Disease, and EMS, Center for Acute Infectious Disease Epidemiology, October 7, 2015

Facility Name: ______________________________

RESIDENT / STUDENT Line List
(Gastrointestinal)

Date: ____________

Resident Name	Sex (M/F)	Age	Floor & Room	SYMPTOMS: Circle the symptom V: Vomit D: Diarrhea N: Nausea F: Fever	SYMPTOMS: Other (Write in Symptom)	Date of Illness Onset	Date of End of Illnes	Stool Specimen Collected (Circle Y/N; if Y, circle result)	Medical Care Required (Circle Y/N; if Y, circle type: Provider Visit, ER/Urgent Care, Hospitalization)	Died? (Y/N; if yes, date)	Comments
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	
				V D N F				Y N + -	Y N PV ER/U Hos	Y N / /	

Please add cases until the linelist is full. Update case information as necessary.