

**ACUTE RESPIRATORY ILLNESS OUTBREAK FOLLOW-UP**

*\*FAX COMPLETE FORM AND LINE LIST TO WAUKESHA COUNTY HEALTH DEPT:* ***262-896-8387***

*\*PLEASE FAX ANY POSITIVE LAB RESULTS APPLICABLE TO OUTBREAK*

|  |  |
| --- | --- |
| DATE: | Telephone #: |
| FACILITY NAME: | Fax #: |
| facility address: | contact person: |
|  | email: |

LABORATORY CONFIRMED DIAGNOSIS (INDICATE ALL THAT PERTAIN):

|  |  |  |
| --- | --- | --- |
| INFLUENZA A | INFLUENZA B | PARAINFLUENZA |
| ADENOVIRUS | RSV | HUMAN METAPNEUMOVIRUS |
| RHINOVIRUS | OTHER (SPECIFY): | |

NAME OF UNIT:

**ONSET DATE OF FIRST RESPIRATORY ILLNESS FOR RESIDENTS:**

**ONSET DATE OF FIRST RESPIRATORY ILLNESS FOR STAFF:**

**ONSET DATE OF LAST RESPIRATORY ILLNESS FOR RESIDENTS:**

**ONSET DATE OF LAST RESPIRATORY ILLNESS FOR STAFF:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | NUMBER EXPOSED | NUMBER ILL | NUMBER HOSPITALIZED | NUMBER OF DEATHS |
| RESIDENTS: |  |  |  |  |
| STAFF: |  |  |  |  |

NAME OF UNIT:

**ONSET DATE OF FIRST RESPIRATORY ILLNESS FOR RESIDENTS:**

**ONSET DATE OF FIRST RESPIRATORY ILLNESS FOR STAFF:**

**ONSET DATE OF LAST RESPIRATORY ILLNESS FOR RESIDENTS:**

**ONSET DATE OF LAST RESPIRATORY ILLNESS FOR STAFF:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | NUMBER EXPOSED | NUMBER ILL | NUMBER HOSPITALIZED | NUMBER OF DEATHS |
| RESIDENTS: |  |  |  |  |
| STAFF: |  |  |  |  |

*\*If there are additional units affected, please add an additional page containing that information.*

COMPLETE SECTION BELOW FOR SUSPECTED OR CONFIRMED INFLUENZA OUTBREAKS ONLY.

INFLUENZA PROPHYLAXIS:

|  |
| --- |
| Was an antiviral administered to exposed individuals?: |
| If yes, please indicate product: |
| Number of residents who received antiviral prophylaxis: |
| Number of staff who received antiviral prophylaxis: |

|  |  |  |  |
| --- | --- | --- | --- |
|  | TOTAL # AT FACILITY | Total # THAT RECEIVED INFLUENZA VACCINE | # ILL THAT RECEIVED  INFLUENZA VACCINE |
| RESIDENTS: |  |  |  |
| STAFF: |  |  |  |