

ACUTE FEBRILE RESPIRATORY ILLNESS AND/OR ACUTE INFECTIOUS PNEUMONIA CONGREGATE-LIVING SETTINGS OUTBREAK REPORT FORM

OUTBREAK INFORMATION			
Outbreak classification <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	Local outbreak tracking number*	First onset date ____/____/____	Last onset date ____/____/____
Pathogen identified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, specify pathogen	Describe clinical case definition (clinical syndrome) used during the outbreak Identify predominant symptoms experienced by at least half of reported cases: <input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Malaise/fatigue <input type="checkbox"/> Chills/Rigor <input type="checkbox"/> Arthralgia / Myalgia <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other1 _____ <input type="checkbox"/> Other2 _____ <input type="checkbox"/> Other3 _____		
	RESIDENTS	STAFF PERSONS	TOTAL
Number lab confirmed cases			
Number of clinical cases			
Total number of persons present during the outbreak period.	<input type="checkbox"/> Census <input type="checkbox"/> Beds		
SETTING INFORMATION			
Setting Type (check all settings where illnesses occurred)			
<input type="checkbox"/> Skilled nursing	<input type="checkbox"/> Residential care facility**	<input type="checkbox"/> Independent living facility**	<input type="checkbox"/> Assisted living facility
<input type="checkbox"/> Other hospital	<input type="checkbox"/> Dormitory**	<input type="checkbox"/> Jail	<input type="checkbox"/> Military facility
<input type="checkbox"/> Cruise ship	<input type="checkbox"/> Prison	<input type="checkbox"/> Shelter**	<input type="checkbox"/> Acute care hospital
<input type="checkbox"/> Camp			
<input type="checkbox"/> Other			
**Describe _____			
Facility Name	Facility Contact Name	Facility Contact Number ()	
DEMOGRAPHICS AND CLINICAL INFORMATION FOR RESIDENT CASE-PATIENTS ONLY (Do not include employee or staff case-patients in this section)			
Age range: ____ to ____ yrs.	Median age if available: _____	Number (%) Female _____	
Number of patients with fever	Highest temperature recorded ____ °F ____ °C	Number with clinical diagnosis of pneumonia	Number with abnormal chest x-ray
Number hospitalized due to outbreak illness _____		Number died due to outbreak illness _____	
CLINICAL INFORMATION for STAFF CASE-PATIENTS ONLY			
Number hospitalized due to outbreak illness _____		Number died due to outbreak illness _____	
LABORATORY TESTING AMONG ALL PATIENTS (RESIDENTS AND STAFF): Please attach copies of test results, if available			
Type of specimens and tests ordered	No. patients tested	Findings (Count by patient, not by specimens tested)	
EXAMPLE NP Swab, commercial rapid antigen NP Swab, PCR (VRDL)	5 5	1 Influenza A/B non-specific; 4 Negative 3 Influenza B, 2 Negative	
Were any patient specimens tested by: (Check all that apply)			
<input type="checkbox"/> The facility (e.g. bedside commercial rapid antigen)		<input type="checkbox"/> A commercial laboratory associated with the facility	
<input type="checkbox"/> State public health laboratory		<input type="checkbox"/> Local public health laboratory	
<input type="checkbox"/> CDC laboratory		<input type="checkbox"/> Other laboratory specify: _____	

*Please use the last 2 digits of current year followed by the jurisdiction-specific 2-digit code followed by a 3-digit sequential number for the outbreak. For example, the first outbreak in 2008 in Orange County would have the outbreak tracking #08-30-001, and their fourth outbreak would be #08-30-004.

CONTROL MEASURE INFORMATION

A. FOR INFLUENZA OUTBREAKS ONLY (if not influenza, skip to B):	Yes	No	Unk	If yes, specify as noted
Were symptomatic residents offered antiviral treatment ?				Number treated ____ Antiviral prescribed: _____
Were asymptomatic residents offered antiviral prophylaxis ?				Number treated ____ Antiviral prescribed: _____
Were residents vaccinated against influenza ≥ 14 days before outbreak began?				If yes, Number _____
Were residents vaccinated against <i>S. pneumoniae</i> ≥ 14 days before outbreak began?				If yes, Number _____
Were residents offered catch-up influenza vaccination after the outbreak began?				If yes, Number _____
Were symptomatic staff persons offered antiviral treatment ?				Number treated ____ Antiviral prescribed: _____
Were asymptomatic staff person offered antiviral prophylaxis ?				Number treated ____ Antiviral prescribed: _____
Were staff persons vaccinated against influenza ≥ 14 days before outbreak began?				If yes, Number _____
Were staff persons offered catch-up influenza vaccination after the outbreak began?				If yes, Number _____

B. FOR ALL OUTBREAKS

<input type="checkbox"/> Facility temporarily closed to new admissions	<input type="checkbox"/> Facility temporarily closed to visitors
<input type="checkbox"/> Ill resident activity restrictions (ill remain in their own rooms)	<input type="checkbox"/> Staff cohorted to specific patients or areas
<input type="checkbox"/> Environmental measures (list)	
<input type="checkbox"/> Other measures (list): _____	
<input type="checkbox"/> Medical interventions used for outbreaks other than influenza (list): _____	

CONTRIBUTING FACTORS: (this section applies ONLY to non-influenza outbreaks)

Please indicate epidemiologic and exposure factors that may have contributed to the outbreak.

<input type="checkbox"/> Close contact with another laboratory-confirmed case	<input type="checkbox"/> Travel related	<input type="checkbox"/> Animal exposure
<input type="checkbox"/> Other environmental exposure: (Describe) _____	<input type="checkbox"/> Other risk factors (list) _____	

ADDITIONAL INFORMATION: If available, please attach a facility map, epidemic curve (graph of outbreak cases by time), laboratory results, and a summary of the local investigation (if completed). If no summary exists, please provide any other important details and descriptions below.

Comments / Remarks:

Attachments / Reports:

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number ()
Facility Report Date	Date Investigation Closed	Date Submitted to State

OUTBREAK DEFINITION

This form should be used to report outbreaks of acute febrile respiratory illness (including influenza like illness) or acute infectious pneumonia in congregate living settings.

Acute febrile respiratory illness is defined as fever $\geq 37.8^\circ\text{C}$ (100°F) and new or worsening cough or shortness of breath or sore throat. This definition includes influenza-like illness (ILI).

Acute infectious pneumonia is defined as clinical symptomatology and new abnormal chest radiograph consistent with pneumonia of infectious etiology that is not likely attributable to aspiration.

An **outbreak** is defined as a grouping of cases within temporal and spatial proximity with a likely common source association between cases or reasonably identifiable chain of transmission. In long term care settings, an outbreak should be suspected when 2 or more cases of acute respiratory infection (with or without fever) occur within 48-72 hours, particularly in residents who are in close proximity of each other (e.g., on the same nursing unit). In a long term care facility, one laboratory confirmed case of influenza is considered an outbreak.

A **congregate living setting** is defined as a setting in which three or more usually unrelated persons reside in close physical proximity. These settings may include hospitals, long term care facilities, assisted living facilities, correctional facilities, etc.