**Suspected Outbreak Intake Form**

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| **Date Facility Notified CHD:** | **Most Recent Onset Date:** | |
| **Facility Name:** | | |
| **Facility Address:** | | |
| **Name of Contact: Title:** | | |
| **Phone: Fax:** | | |
| **Email address:** | | |
| **Type of Facility:**  Nursing Home  Daycare  School  Prison  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Entire facility affected  or specify unit/wing/classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Non-Staff** Number ill: Number potentially exposed: | | |
| **Staff** Number ill: Number potentially exposed: | | |
| **Type of Illness:**  GI  Respiratory/ILI  Rash  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Estimated Duration of Illness**  (e.g., 24-48 hours, 1-5 days) |
| **Signs and Symptoms (check all that apply):**   |  |  |  | | --- | --- | --- | | Abdominal cramps | Diarrhea | Nausea | | Bloody stools | Fatigue | Pneumonia | | Body/Muscle aches | Fever | Runny nose | | Chills | Headache | Sore throat | | Cough | Nasal congestion | Vomiting | | Other (specify): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Rash description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Laboratory Testing:** Laboratory Confirmed Specimens: Yes / No (circle one)  Laboratory Findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | Will drop off specimen collection kits for testing at BPHL | | | |
| **Case Outcomes (specify number; individual can be counted in more than one category):**   |  |  | | --- | --- | | \_\_\_\_\_ Saw Primary Care Provider | \_\_\_\_\_ ED/Urgent Care Visit | | \_\_\_\_\_ Inpatient Hospitalization | \_\_\_\_\_ Died | | Requested line list for demographics and details for further follow up | | | | |
| **Control Measures:**   |  |  | | --- | --- | | Verbally provided prevention measures specific to syndrome | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Emailed/Faxed prevention measures specific to syndrome | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |