RESIDENT: Respiratory Outbreak Line Listing Form

Thunder Bay District Health Unit

Institution Name:	Unit:	Outbreak Number: 2262-	Date Reported to Health Unit:

Causative Agent:	Contact Person:		PHN:	TBDHU Fax: 807-625-4822

Case Definition:

Case Identifiers				Symptom Information														Testing				Isolation			Immunization			Treatment		Outcome		
#	Name	DOB	Room #	Symptom Onset Date	Cough - new or worsening	Shortness of breath / Dyspnea	Sore Throat / Hoarseness	Nasal Congestion / Runny nose	Fever	Chills	Myalgia (muscle aches / pain)	Fatigue / Malaise	Headache	Nausea	Vomiting	Diarrhea	Other (specify in comments)	Nasopharyngeal Swab (Date and type)	Result: Positive (P), Negative(N)	Nasopharyngeal Swab (Date and type)	Result: Positive (P), Negative(N)	Date Isolation Initiated	Date symptoms resolved	Date Isolation Discontinued	# of COVID-19 immunizations	Date of most recent COVID-19 Vaccine	Date of Influenza Immunization (mm/dd/yy)	COVID-19 Antiviral (Y/N)	Influenza Antiviral (Y/N)	Hospitalized Date (dd/mm/yy)	Death Date (dd/mm/yy)	Notes/ Comments
1	Mr Example	4-Mar-37	311-B	4-Mar	x						x							RAT 4/3/2023	P	PCR 5/3/2023	P	4-Mar	8-Mar	9-Mar	5*	1-Jan-23	26-Oct-22	Y	N			Paxlovid