STAFF: 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		Exclusion			Immunization			Outcome		
#	Name	DOB	Areas Worked	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)	Last Date of Work	Date Symptoms Resolved	Date Returned to Work	# of COVID-19 immunizations	Date of most recent COVID-19 Vaccine	Date of Influenza Immunization (mm/dd/yy)	Hospitalized Date (dd/mm/yy)	Death Date (dd/mm/yy)	Notes/ Comments
1	Mr Example	4-Mar-37	Kitchen/2B	1-Aug	x						x							RAT 1/8/2023	P	1-Aug	3-Aug	4-Aug	3	1-Jan-23	26-Oct-22			Paxlovid