RESIDENT: Respiratory / COVID-19 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 RSV vaccination	Date of Influenza Immunization	COVID-19 Antiviral (Y/N)	Influenza Antiviral (Y/N)	Hospitalized Date (dd/mm/yy)	Death Date (dd/mm/yy)	Notes/ Comments
1	Last, First	4-Mar-37	311-B	4-Mar	x						x							FLUVID 4/3/2023	P	MRVP 5/3/2023	P	4-Mar	8-Mar	9-Mar	5	1-Jan-23	12-Nov-23	26-Oct-22	Y	N			Paxlovid

Last Updated: Feb 2024