

INFLUENZA-LIKE-ILLNESS OUTBREAK LINE LIST (PATIENTS/RESIDENTS)

Complete and fax daily to [Infection Prevention and Control](#)

Facility Name: _____ Unit: _____ Telephone: _____

Contact Person: _____ Telephone: _____

DEMOGRAPHICS (one line per patient/resident)		NP SWAB	SIGNS & SYMPTOMS		SUDDEN ACUTE ONSET CLINICAL SYMPTOMS (✓ tick all applicable)						Acute Admit/ Tsfr Date	Comments /Other (i.e. vaccination date; Tamiflu start/stop date)
NAME (LAST, First) MRN & PHN	ROOM BED #	SENT DATE	Onset Date & Time	Resolved Date	Fever	Cough	Headache	Sore Throat	Sore Muscles/ Joints	Extreme Fatigue		