Lambton Public Health

160 Exmouth St.
Point Edward, On, N7T 7Z6
Telephone: 519-383-8331
Toll Free: 1-800-667-1839
www.lambtonpublichealth.ca

Facility Outbreak Line List

Fax line lists daily by 10 am to 519-383-7092 until outbreak is declared over by LPH

Facility Name: _____
Facility Address: _____
Facility Phone & Ext. _____
Contact Person #1: _____
Contact Person #2: _____

Select ONLY one:
☐ Respiratory
☐ Enteric

Select ONLY one:
☐ Resident
☐ Patient
☐ Children
☐ Staff

Line List Outbreak # 2242- _____
Index Case Symptom Onset Date: YY-MM-DD _____
Control Measures Stared Date: YY-MM-DD _____
Submission Date: YY-MM-DD _____
Submitted by: _____

Respiratory	Enteric	Case Definition
Submit line list when: **[1]** Two or more cases of acute respiratory infections occur within 48hrs with a common epi-link (e.g., Unit, floor) in residents. ***OR*** **[2]** One or more laboratory-confirmed case(s) of influenza in a resident. ***OR*** **[3]** One or more positive tests for Covid-19 in residents. ***OR*** **[4]** Directed by LPH	**Submit line list when 2 or more people have:** **[1]** Two or more episodes of diarrhea (e.g., loose/watery bowel movements) within a 24-hour period, ***OR*** **[2]** Two or more episodes of vomiting within a 24-hour period, ***OR*** **[3]** One or more episodes of diarrhea *AND* one or more episodes of vomiting within a 24-hour period	Check all as defined by LPH**:** ☐ **Fever**(≥37.8°C) ☐ **Nausea/Vomiting** ☐ **Sore throat/ Hoarseness** ☐ **Headache** ☐ **Diarrhea** ☐ **Nasal Congestion/ Sneezing** ☐ **Malaise/Fatigue** ☐ **Shortness of Breath** ☐ **Loss of taste/smell** ☐ **New Cough** ☐ **Muscle Aches** ☐ **Other:** _____

Case Demographics			Isolation	Symptoms (new or worsening)										Specimans		Vaccination/Treatment			Complications/Outcome				
Case Name (Last, First)	Date of Birth YYYY-MM-DD	Unit/Room # (resident) OR Unit Worked/Role (Staff)	Isolation date or date of last shift. MM-DD	Symptom onset date MM-DD	Fever/Abnormal Temp (Celsius)	New/worsening cough	Shortness of Breath	Hoarseness/Sore Throat	Runny Nose/Nasal Congestion	Headache	Fatigue/Malaise/Myalgias	Loss of taste/smell	Vomiting # of episodes	Diarrhea # of episodes **	Specimen Collection Date MM-DD	Type of test & result (+ or -) (RAT, PCR, MRVP, stool)	Covid-19 Vaccine (# of doses)	Influenza Vaccine MM-DD	Antiviral Treatment MM-DD	Clinical/X-RAY evidence of pneumonia MM-DD	Hospitalization Date MM-DD	Hospital Discharge Date MM-DD	Death MM-DD	Out of Isolation OR Return to Work Date MM-DD
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If resident is experiencing new onset of diarrhea, collect stool sample using enteric outbreak stool kit for viral & bacterial testing.

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