WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

Facility Outbreak Line List

Fax line lists daily by **10:00 AM** to **519-977-5097** until outbreak declared over by the WECHU.

Phone: 519-258-2146 ext. 1420
After Hours: 519-973-4510

Facility Name: _____

Facility Address: _____

Facility Phone and Ext: _____

Contact Person #1: _____

Contact Person #2: _____

Select ONLY one:
- ☐ **Respiratory**
- ☐ **Enteric**

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

Line List Outbreak # 2268- _____-_____

Index Case Symptom Onset Date: YYYY-MM-DD _____

Control Measures Started Date: YYYY-MM-DD _____

Submission Date: YYYY-MM-DD _____

Submitted By: _____

Respiratory (including COVID-19) Outbreak Criteria

1. Two or more cases of acute respiratory infections (ARI) with symptom onset within 48hrs and an epidemiological link (e.g., same unit, floor) suggestive of transmission within the setting **AND** testing is not available or all negative **OR**
2. Two or more cases of test-confirmed ARI with symptom onset within 48hrs and an epi-link suggestive of transmission within the setting **OR**
3. Three or more cases of ARI with symptom onset within 48hrs and an epi-link suggestive of transmission within the setting **AND** testing is not available or all negative.

Enteric Outbreak Criteria

1. Two or more cases meeting the case definition with a common epidemiological link (e.g., same unit, floor) with initial onset within a 48-hour period

Enteric Case Definition:

- Two or more episodes of diarrhea (e.g., loose/water bowel movements) within a 24 hour period, **OR**
- Two or more episodes of vomiting within 24-hour period, **OR**
- One or more episodes of diarrhea **AND** one or more episodes of vomiting within a 24 hour period.

Case Definition

Check all as defined by **WECHU:**

- ☐ **Fever**(≥37.8°C)
- ☐ **Headache**
- ☐ **Malaise/Fatigue**
- ☐ **New Cough**
- ☐ **Rash**
- ☐ **Nausea/Vomiting**
- ☐ **Diarrhea**
- ☐ **Shortness of Breath**
- ☐ **Muscle Aches**
- ☐ **Sore throat/ Hoarseness**
- ☐ **Nasal Congestion/ Sneezing**
- ☐ **Loss of taste/smell**
- ☐ **Other:** _____

Case Demographics			Isolation	Symptoms (new or worsening)											Specimens Diagnostics		Vaccination/Treatment				Complications/Outcome				
Case Name (Last, First)	**Date of Birth** YYYY-MM-DD	**Unit/Room #** (resident) OR **Unit Worked/Role** (Staff)	**Isolation & additional precaution start date** or **date of last shift.** MM-DD	Symptom onset date MM-DD	Fever/Abnormal Temp (Celsius)	Rash	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, NAAT, Stool)	Covid-19 Vaccine (# of doses)	Influenza Vaccine MM-DD	Antiviral Treatment MM-DD	Antibiotic 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

**If resident is experiencing new onset of diarrhea, collect stool sample using enteric outbreak stool kit for viral and bacterial testing.

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