Fax completed forms to DOH
Communicable Disease Epi
Fax: 206-364-1060

Outbreak Reporting Form - Influenza-like Illness

Date of initial notification to DOH: ___/___/_____

Date report sent to DOH:___/___/_____

Form Status: ☐ Preliminary report ☐ Final report

LHJ Cluster #: __________

LHJ Cluster Name: __________

DOH outbreak #: ________

LHJ INFORMATION

Local health jurisdiction (LHJ) ______________________

Contact person ______________________

Initial LHJ notification date / / ___

Investigation start date___/___/ Investigation completion date / / ___

REPORTING FACILITY INFORMATION

Facility Name ______________________

Facility Address ______________________

Facility City______________Facility Type ______________

Person reporting ______________________

Title______________________

Phone (_____)______- ________

CASE INFORMATION

Total # symptomatic residents		Total # residents in facility		Date first case became ill:___/___/____
Total # symptomatic staff		Total # staff in facility		Date last case became ill:___/___/____

LABORATORY, HOSPITALIZATIONS, DEATHS

Any flu testing? ☐ Yes ☐ No If yes: # tested_____ # pos_____ Type of flu: ☐ A________ ☐ B_____

Type(s) of flu testing performed ______________________

Any COVID-19 testing? ☐ Yes ☐ No If yes: # tested_____ # pos_____

Types(s) of COVID-19 testing performed ______________________

COVID-19 outbreaks in Long-term care facilities are reportable to DOH.

RSV ☐ Yes ☐ No Human metapneumovirus ☐ Yes ☐ No Other: ______________________

Any hospitalizations? ☐ Yes ☐ No If yes, how many _____

Any deaths? ☐ Yes ☐ No If yes, how many _____

PUBLIC HEALTH ACTIONS TAKEN (check all that apply)

- ☐ Discussed "Checklist for Controlling Influenza in LTCF" ☐ Yes ☐ No Date:___/___/______
- ☐ Faxed written materials to LTCF administrator (Line List, Checklist, CDC guidance) ☐ Yes ☐ No Date:___/___/______
- ☐ Recommended PEP (influenza only) ☐ Yes ☐ No Date: ___/___/______
- ☐ Implemented PEP (influenza only) ☐ Yes ☐ No Date: ___/___/______
- ☐ Other______________________
- ☐ Request for DOH assistance
- ☐ Request for DOH ICAR Consultative Infection Prevention visit

DISCUSSION / CONCLUSION / NOTES