Line Listing for Respiratory Illness Outbreaks

List for Residents____ Employees____ (check one)

Name of Facility:_____ Address:_____

Contact Person:_____ Telephone:_____

							Signs and Symptoms													Laboratory Results (if applicable)						
NAME	**Age (Optional)**	**Sex (Optional)**	**Room No. or Shift* & Unit***	**Date of Onset**	**Shift of Onset**	**Duration of Illness**	**Fever (Record highest temp.)**	**Cough**	**Sore Throat**	**Runny Nose**	**Congestion - Nasal**	**Congestion - Chest**	**Muscle Aches**	**Vomiting or Diarrhea**	**Pneumonia**	**X-ray Results (if taken)**	**Influenza Vaccine Y/N (Date)**	**Hospitalized**	**Death (Date)**	**Viral Throat Culture (Date)**	**Bacterial Sputum Culture (Date)**	**Rapid Antigen Detection (Date)**	**Serology - acute (Date)**	**Serology-convalescent (date)**	**Antiviral if given (Date)**	**Pneumococcal Vaccine Y/N (Date)**

***List shift and unit (or ward) for employee cases**