

Respiratory Outbreak Staff Line Listing

Outbreak Number: 2236 - _____ - _____

To be reviewed and faxed daily to 905-825-1009 by 11:00 a.m.

Facility: _____ Date Reported to Public Health: _____ Investigator: _____ Page No: _____

Facility Contact Person: _____

Telephone: _____

Fax: _____

			Symptoms							Testing (if known)		Status
			Fever / abnormal temp	Runny Nose/ Sneezing	Nasal Congestion	Sore throat/ Hoarse voice	Cough	Malaise	Other – Specify:	NPS collected? (if known) (date)	NPS result (if available) (date)	Sx. Resolved (date d/m)
First Name, Last Initial	Flu Immunization	Symptom Onset Date										
	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ <small>yyyy / mm / dd</small>										
Work location (Unit) _____			Position/Role _____				Last Day Worked ____/____/____ <small>yyyy / mm / dd</small>					
First Name, Last Initial	Flu Immunization	Symptom Onset Date										
	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ <small>yyyy / mm / dd</small>										
Work location (Unit) _____			Position/Role _____				Last Day Worked ____/____/____ <small>yyyy / mm / dd</small>					
First Name, Last Initial	Flu Immunization	Symptom Onset Date										
	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ <small>yyyy / mm / dd</small>										
Work location (Unit) _____			Position/Role _____				Last Day Worked ____/____/____ <small>yyyy / mm / dd</small>					
First Name, Last Initial	Flu Immunization	Symptom Onset Date										
	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ <small>yyyy / mm / dd</small>										
Work location (Unit) _____			Position/Role _____				Last Day Worked ____/____/____ <small>yyyy / mm / dd</small>					
First Name, Last Initial	Flu Immunization	Symptom Onset Date										
	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ <small>yyyy / mm / dd</small>										
Work location (Unit) _____			Position/Role _____				Last Day Worked ____/____/____ <small>yyyy / mm / dd</small>					
First Name, Last Initial	Flu Immunization	Symptom Onset Date										
	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ <small>yyyy / mm / dd</small>										
Work location (Unit) _____			Position/Role _____				Last Day Worked ____/____/____ <small>yyyy / mm / dd</small>					

Ensure that only staff cases meeting case definition are reported on the line list

Respiratory Outbreak Case Definition: Any staff with 2 or more of the following (new or worsening) symptoms: fever cough
 runny nose/sneezing nasal congestion sore throat/hoarse voice malaise other (specify) _____

COVID-19 Case Definition: Any staff with 1 or more (new or worsening) symptoms compatible with COVID-19 ([as per most recent Ministry of Health Document: COVID-19 Reference Document for Symptoms](#))

