Regional Municipality of Halton
HEAD OFFICE: 1151 Bronte Rd, Oakville, ON L6M 3L1
905-825-6000 | Toll free: 1-866-442-5866

LTCH, RH and Independent Living Settings
Outbreak Cover Sheet and Line List

Please submit a completed cover sheet **and** line list daily by 12pm to Halton Region Public Health via fax (905-825-1009) or using Halton Region's online portal.

For questions, please contact your assigned investigator.

Facility Name:	
Today's Date:	
Name and contact details of individual completing cover sheet and line list:	
Public Health Investigator:	
Outbreak Number:	
	Indicate outbreak type: ☐ Enteric ☐ Respiratory
Case Definition:	
Today's Key Concerns:	
No concerns today: ☐	
Specify concerns, if any: (e.g. staffing concerns, IPAC, PPE supplies, testing, etc.)	
Today's Line List Updates:	
No changes to today's line list: ☐	
Specify changes to line list, if any: (e.g. new cases, hospitalizations, deaths)	

Would you like a call from your Public Health Investigator today? ☐ Yes ☐ No

Case Counts	Residents	Staff
Total # of new cases:		
Total # of active cases:		
Total # of resolved cases:		
Total # of deaths:		
Total # of hospitalizations:		

Confidentiality Clause
This message, including any attachments, is privileged and intended only for the person(s) named above. This material may contain confidential or personal information which may be subject to the provisions of the Municipal Freedom of Information & Protection of Privacy Act. Any other distribution, copying or disclosure is strictly prohibited. If you are not the intended recipient or have received this message in error, please notify us immediately by telephone or fax and permanently delete the original transmission from us, including any attachments, without making a copy. Thank you.

Page Number:

Facility Name:

Outbreak Number:

Resident Information	Home Area and Room #	Onset Date	Resolved Date	Symptoms: Respiratory: Fever / Abnormal Temp.	Headache	Nasal Congestion / Runny Nose	Sore Throat / Hoarse Voice	Cough	Shortness of Breath	Fatigue / Malaise / Myalgia	Enteric: Vomiting # of episodes	Diarrhea # of episodes	Fever / Abnormal Temp.	Other (specify)	Diagnostics: Respiratory: Other Resp. Viruses rapid molecular result (specify agent)	COVID-19 rapid antigen result (+/-)	Date of Molecular Test Collection	COVID-19 molecular test result (+/-)	Other Resp. Viruses molecular test result (specify agent)	Enteric: Stool Collection Date	Test Result (specify agent)	Complications: Clinical / X-ray evidence of pneumonia (Y/N)	Hospitalization Date (if applicable)	Repatriation Date (if applicable)	Date of Death (if applicable)
Full Name:		___/___/__ yyyy/mm/dd	___/___/__ yyyy/mm/dd																						
Date of birth: ____/___/___ yyyy/mm/dd	Roommate? ☐Yes ☐No	**For Influenza Outbreaks ONLY** Influenza vaccine received? ☐ Yes, date: ____/____/___ ☐ No																							
				Antivirals received? ☐ Prophylaxis ☐ Treatment											**Comments:**										
Full Name:		___/___/__ yyyy/mm/dd	___/___/__ yyyy/mm/dd																						
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			Fever / Abnormal Temp.	Headache	Nasal Congestion / Runny Nose	Sore Throat / Hoarse Voice	Cough	Shortness of Breath	Fatigue / Malaise / Myalgia	Vomiting # of episodes	Diarrhea # of episodes	Fever / Abnormal Temp.		
Full Name:	___/___/__ yyyy/mm/dd	___/___/__ yyyy/mm/dd												
Work location (home area):							Position/Role:							
Testing completed? If yes, specify agent:							Outbreak related case? (Y / N):							
Last day worked:														
Full Name:	___/___/__ yyyy/mm/dd	___/___/__ yyyy/mm/dd												
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