

Influenza and ILI Outbreak Line List for Healthcare Facilities

RESIDENTS



Facility Name: _____

Contact Person/Phone No.: _____

Outbreak Number : _____

Date: _____

Total Number of Residents at time of outbreak: _____

Resident Information			Resident Location		Vaccination status		Illness Description							Diagnostics						Outcome				
Resident Name	Date of birth or Age	Sex (M/F)	Room #	Unit/Ward	Influenza (Y/N), if yes, provide date	Pneumococcal (Y/N), if yes, provide date	Date of illness onset	Fever (Y/N) or highest temperature (°F)*	Cough (Y/N)	Myalgia/Body Aches (Y/N)	Chills (Y/N)	Sore throat (Y/N)	Shortness of breath (Y/N)	Other (Y/N)	Chest X-ray confirmed pneumonia (Y/N)	Doctor visit (Y/N)	Specimen collected (Y/N)	Specimen Type (NP, Sputum, Other)	Diagnosis/Lab Result	Antivirals (Y/N), Date started/Date ended	Antibiotics (Y/N), Date started/Date ended	Final Diagnosis Influenza/Pneumonia/Other	Hospitalized (Y/N)	Died (Y/N, if yes, date)
1.																								
2.																								
3.																								
4.																								
5.																								
6.																								
7.																								
8.																								
9.																								
10.																								

*Self-reported or highest temperature: measured oral, under armpit or rectal