RESPIRATORY OUTBREAK UPDATE FORM

Please send Monday-Friday (excluding statutory holidays) to YRPH. include this completed form each time a line list is submitted by fax (905-660-4889) or secure FTP site. For more questions, please contact your assigned investigator.

Outbreak #:		
Facility Name:		
Facil	ity Response:	
Today's Date:		
Name and contact details of individual		
completing outbreak update form and line list:		
Total# of line list pages:		
Today's	Key Concerns:	
No co	oncerns today:	
Concerns identified (e.g. staffing concerns,		
IPAC, PPE supplies, PPE breaches, etc.):		
Line List U	Jpdates for Today:	
No changes	today to the line list:	
Any changes to today's line list:		
 Please indicate any new cases, new 		
symptomatic individuals,		
hospitalizations and deaths with		
corresponding line list page number		
and line list client number		
Cumulative (Total) Counts:	Resident	Staff
Total # of Cases:		
Total # of related deaths:		
Total # of hospitalizations:		
Please ensure that each new hospitalization and		spitalization and Death
Outbreak chart and faxed and included in the lin		
	recautions in Place:	
Last IPAC inspection date:		
Units/floors on droplet contact precautions:		
	ting Details:	
Next surveillance testing date(s):		
	Resident	Staff
# of pending COVID-19 surveillance tests:		
# of pending MRVP surveillance tests:		
# of pending FLUVID surveillance tests:		
# of pending case/contact tests:		
	nation Details:	
Next immunization date(s):		
	Resident	Staff
# of pending vaccinations to be		
administered:		

York Region Public Health 1-877-464-9675 TTY 1-866-512-6228 york.ca



Institution Name:	Outbreak number: 2270- 20		Date outbreak Declared:	of of
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Case	Legal Name (LAST	Health Card Number	Date of Birth (yyyy/mm/dd)	Floor/room number	X	Flu Immunization Date (yyyy/mm/dd)	Contact Phone Number	Position Role	st L	ast day worked	Onset date of first (yyyy/mm/dd)	Fever ≥ 37.8°C/100°F	New/worsening cougn	Loss of taste / smell	Runny/ congested	Sore throat	Nausea / Vomiting (# of vomiting episodes)	arrt	Abdominal Pain	Other Symptoms (List in comments)	ipid llec] X	COVID results (Pos/Neg/Ind/Pending)	/RF te (lue os/l	Other Causitive Agents	Antivirals Date Started (yyyy/mm/dd)	Antibiotics date started (yyyy/mm/dd)	Initiated (yyyy/mm/dd)	Discontinued (yyyy/mm/dd)	Pneumonia (yyyy/mm/dd)	Hospitalized date (yyyy/mm/dd)	Death (yyyy/mm/dd)	ect.) and clearance/return
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Institution Name:	Outbreak number: 2270	- 20			Date outbreak Declared:	P	age	of
Floor/Unit:	Residents or staff?	Resident List	Staff List	□Visitor List	Facility representative name & contact information:			

Case Definition for Outbreak:		T		
		Prophylaxi and	S Droplet/ Contact	
Case Identification	Symptoms	Testing Dates and Result Antivirals		Comments
Immunization	When assessing for symptoms. Evaluate wether	Multiplex	Θ	
Status Status	they are new, worsing, or different from the individuals baseline status	COVID-19 Respiratory Organisms	(p	
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Case # (sequentially) (a) Last unit(s) Case # (sequentially) (b) Last unit(s) Case # (sequentially) (c) Last unit(s) (c) Last day worked (c) Last day worked	Onset date of first symptom (yyyy/mm/dd) Fever ≥ 37.8°C/100°F New/worsening cough Shortness of breath Loss of taste / smell Runny/ congested nose sport throat Nausea / Vomiting (# of vomiting episodes) Abdominal Pain Other Symptoms (List in comments)	Kapid Antigen lest collection date (yyyy/mm/dd) COVID-19 NP swab collection date (yyyy/mm/dd) COVID results (Pos/Neg/Ind/Pending) MVRP swab collection date (yyyy/mm/dd) Influenza Result (Pos/Neg) Other Causitive Agents Antivirals Date Started (yyyy/mm/dd)	(yyyy/mm/dd) Initiated (yyyy/mm/dd) Discontinued (yyyy/mm/dd) Pneumonia (yyyy/mm/dd) Hospitalized date (yyyy/mm/dd)	
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Institution Name:	Outbreak number: 2270)- 20			Date outbreak Declared:	F	Page	of
Floor/Unit:	Residents or staff?	Resident List	Staff List	□Visitor List	Facility representative name & contact information:			

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Institution Name:	COVID Outbreak Management for Institutions
Outbreak number: 2270- 20 -	

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	Demographics				Hospitalization					De	eath	
Room number	Resident / patient	Date of birth (yyyy/mm/dd)	Admission date (yyyy/mm/dd)	Name of hospital	Reason for hospitalization	Admitted to ICU (yyyy/mm/dd)	Outbreak related (Y/N)	Date of discharge (yyyy/mm/dd)	Date of death (yyyy/mm/dd)	Cause of death	Outbreak related (Y/N)	Post mortem swab collected (Y/N)

List of Hospitals	- Cortellucci Vaughan Hospital - Mackenzie Health Richmond Hill Hospital - Markham Stouffville Hospital - Southlake Regional Hospital	 Branson Ambulatory Care Centre Hospital for Sick Children Humber River Regional Hospital (specify site) Michael Garron Hospital Mount Sinai Hospital North York General Hospital 	 - Princess Margaret Hospital - Royal Victoria Regional Health Centre - Scarborough & Rough Hospital (specify site) - Sunnybrook Health Sciences Centre - St. Michael's Hospital - St. Joseph's Health Sciences Centre 	 Toronto General Hospital Toronto Western Hospital Trillium Health Centre West Park Hospital William Osler Hospital (specify site) Women's College Hospital
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Institution Name:	COVID Outbreak Management for Institutions
Outbreak number: 2270- 20 -	

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	Demographics				Hospitalization					De	eath	
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Institution Name:	COVID Outbreak Management for Institutions
Outbreak number: 2270- 20 -	

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Demographics			Hospitalization						Death			
Room number	Resident / patient	Date of birth (yyyy/mm/dd)	Admission date (yyyy/mm/dd)	Name of hospital	Reason for hospitalization	Admitted to ICU (yyyy/mm/dd)	Outbreak related (Y/N)	Date of discharge (yyyy/mm/dd)	Date of death (yyyy/mm/dd)	Cause of death	Outbreak related (Y/N)	Post mortem swab collected (Y/N)

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Institution Name:	COVID Outbreak Management for Institutions
Outbreak number: 2270- 20 -	

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Demographics			Hospitalization						Death			
Room number	Resident / patient	Date of birth (yyyy/mm/dd)	Admission date (yyyy/mm/dd)	Name of hospital	Reason for hospitalization	Admitted to ICU (yyyy/mm/dd)	Outbreak related (Y/N)	Date of discharge (yyyy/mm/dd)	Date of death (yyyy/mm/dd)	Cause of death	Outbreak related (Y/N)	Post mortem swab collected (Y/N)

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Facility Name: _____ Outbreak Number: 2270-20 YY - #####

Facility Representative Name and Contact Information:

STEPS FOR UPLOADING OUTBREAK DOCUMENTS TO YORK REGION SECURE NETWORK (FTP SITE)

