

LONG-TERM CARE INFLUENZA-LIKE ILLNESS OUTBREAK FOLLOW-UP REPORT

Influenza-like illness (ILI): a cough and fever ($\geq 100^{\circ}$ F) or chills. Influenza is confirmed when an individual has a positive culture or rapid-antigen test for influenza and respiratory symptoms.

ILI Outbreak: suspected when three (3) or more cases of ILI are detected on a single unit during a period of 48 to 72 hours. An ILI outbreak is confirmed when at least one resident has a positive culture or rapid-antigen test for influenza.

REPORTER INFORMATION

FACILITY NAME:			
NAME OF REPORTER:		TITLE/DEGREE:	
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
PHONE#:		FAX#:	

FACILITY INFORMATION

Type of long-term care facility (check only one):			
<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Combined Care	<input type="checkbox"/> Other
Date of Onset of Illness for First Case:		Date of Onset of Illness for Last Case:	

A. RESIDENT INFORMATION

1. a. Total number of residents in facility during outbreak: _____
- b. If your facility is divided into units or wings, provide the breakdown of residents per unit or wing. Attach additional sheets if necessary.

<u>Wing</u>	<u># of Residents</u>

2. Age range of residents (also, median if known): _____
3. Total number of residents vaccinated during the current flu season prior to outbreak: _____

B. STAFF INFORMATION

4. a. Total number of staff in facility during outbreak: _____
- b. If your facility is divided into units or wings, provide the breakdown of staff per wing/unit. Attach additional sheets if necessary.

<u>Wing</u>	<u># of Staff</u>

Any staff that work in more than one wing?

Yes No If yes, how many? _____

c. How many of these staff (*if multiple wings, please provide breakdown for each wing*):

	<u># of Staff</u>	<u>Age Range of Staff</u>	<u># Vaccinated</u>
Work directly with residents			
Have no contact with residents			

OUTBREAK INFORMATION

7. a. Were any specimens sent to a commercial laboratory for influenza rapid diagnostic testing? Yes No

b. If yes, list the name of the laboratory performing the test: _____

TREATMENT INFORMATION

8. Were antivirals used for treatment of residents (*those with ILI symptoms*) during the outbreak? Yes No

9. Were antivirals used for prophylaxis of residents (*those exposed, but without ILI symptoms*) during the outbreak? Yes No

10. Were antivirals used for treatment of staff (*those with ILI symptoms*) during the outbreak? Yes No

11. Were antivirals used for prophylaxis of staff (*those exposed, but without ILI symptoms*) during the outbreak? Yes No

ISOLATION

12. Were residents **with ILI** isolated from other residents? Yes No

13. Date first resident(s) with ILI was isolated: _____

14. Number of residents with ILI who were isolated during the outbreak: _____

QUARANTINE

12. Were residents **without ILI** quarantined from other residents? Yes No

13. Date first resident(s) was quarantined: _____

14. Number of residents who were quarantined during the outbreak: _____

COMMENTS

THANK YOU!!! PLEASE FAX TO (808) 586-4595

Please fill out the attached sheets. Thank you for your assistance with influenza surveillance in Hawai'i.
Contact the Hawaii Department of Health's Disease Investigation Branch at **(808) 586-4586** if you have any questions.

RESIDENTS INFLUENZA-LIKE-ILLNESS (ILI) TRACKING SHEET (Attach additional sheets if necessary)

Name (Last, First)	Wing or Unit (if applicable)	DOB	Sex	Age	Date of ILI Onset	Date Specimen Collected	Rapid Test Result (if known)	Flu Vaccination (y/n)	Vaccination Date	Fever (°F)	Cough	Sore Throat	Malaise	Chills	Muscle Aches	Diarrhea	Vomiting	Headache	Pneumonia*?	Date Hospitalized* (if applicable)	Mortality*?	Treatment	
<i>Ex. Smith, John</i>		<i>4/18/1996</i>	<i>M</i>	<i>7</i>	<i>12/20/2003</i>	<i>12/20/2003</i>	<i>Influenza A</i>	<i>Yes</i>	<i>9/30/2003</i>	<i>102.1</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>						<input checked="" type="checkbox"/>	<i>Y</i>	<i>12/24/2003</i>	<i>N</i>	<i>Tamiflu</i>
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* Please indicate if resident developed pneumonia (clinical diagnosis is sufficient), was hospitalized or died within 2 weeks of ILI onset.

STAFF INFLUENZA-LIKE-ILLNESS TRACKING SHEET (Attach additional sheets if necessary)

Name (Last, First)	Wing or Unit (if applicable) / Type of Staff (Nursing, Admin, etc.)	DOB	Sex	Age	Date of ILI Onset	Date Specimen Collected	Rapid Test Result (if known)	Flu Vaccination (y/n)	Vaccination Date	Fever (°F)	Cough	Sore Throat	Malaise	Chills	Muscle Aches	Diarrhea	Vomiting	Headache	Pneumonia*?	Date Hospitalized* (if applicable)	Mortality*?	Treatment	
<i>Ex. Smith, John</i>	<i>Wing A / Nursing</i>	<i>4/18/1956</i>	<i>M</i>	<i>47</i>	<i>12/20/2003</i>	<i>12/20/2003</i>	<i>Influenza A</i>	<i>Yes</i>	<i>9/30/2003</i>	<i>102.1</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>	<i>Y</i>	<i>12/24/2003</i>	<i>N</i>	<i>Tamiflu</i>	
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