

Outbreak Identifier:

MI Outbreak ID Number:

County:

NORS ID:

Date:



Initial Report

Final Report

Cluster and Facility Outbreak Notification Report Form

Type of Outbreak: Gastrointestinal Respiratory Rash Other: _____

Person Providing Report:

Name:		Phone:	
E-mail:		Alt Phone:	

Facility Information:

Facility Name:			
Address:			
Facility Contact Person:		Phone:	
Affected Unit(s)/ Floor(s):			

Type of Facility:

- | | |
|---|--|
| <input type="checkbox"/> Healthcare (Please specify) | <input type="checkbox"/> Adult Day Care |
| <input type="checkbox"/> Acute Care | <input type="checkbox"/> Child Day Care/ K-12 School |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Event (e.g., wedding, party, funeral) |
| <input type="checkbox"/> Critical Access | <input type="checkbox"/> Restaurant |
| <input type="checkbox"/> Long-term Acute Care | <input type="checkbox"/> Senior Apartments/ Retirement Center |
| <input type="checkbox"/> Long-term Care/ Nursing Home | <input type="checkbox"/> College / University |
| <input type="checkbox"/> Outpatient (e.g., dialysis center, ambulatory surgical center) | <input type="checkbox"/> Other: _____ |

Epidemiology:

****“Int” = Initial Case Count**

Onset Date of First Case:			Date of Last Onset:		
Duration (range, average):			Incubation Period (range, average):		
Suspected Etiology:					
Total Number Ill:	Int:	Final:	Number of Secondary Cases:	Int:	Final:
Adults:	Int:	Final:	Hospitalized Cases:	Int:	Final:
Children:	Int:	Final:	Deaths:	Int:	Final:
Ill Employees:	Int:	Final:	Ill Residents/ Patients:	Int:	Final:
Total Employed:	Int:	Final:	Total Population:	Int:	Final:
Ill Food Handlers:	Int:	Final:	Ill Visitors:	Int:	Final:

Symptom Presentation:

Symptom(s)	Symptom Present?	Number of Cases with Symptom	Total # of Cases with Information Available
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Abd Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Fever ° _____ (highest recorded)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bloody Stools	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Respiratory (e.g., coughing, wheezing)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Skin and soft tissue wound/damage	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other :	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Specimen Testing:

- | | |
|---|---|
| <input type="checkbox"/> Declined | <input type="checkbox"/> Respiratory Swab/ Secretion: _____ |
| <input type="checkbox"/> Stool- Norovirus | <input type="checkbox"/> Blood: _____ |
| <input type="checkbox"/> Stool - Bacterial | <input type="checkbox"/> Wound/Skin Cultures: _____ |
| <input type="checkbox"/> Stool - Ovum and Parasites | <input type="checkbox"/> Food: _____ |
| | <input type="checkbox"/> Other: _____ |

No. of Specimens Collected	Test Ordered	Laboratory Performing Tests	Shipping Date	Results

Consultation Provided:

Date Prevention and Control Actions Initiated: _____

- | | |
|---|---|
| <input type="checkbox"/> Environmental cleaning guidelines | <input type="checkbox"/> Infection control precautions |
| <input type="checkbox"/> Employee restrictions | <input type="checkbox"/> Patient cohorting, isolation, and restrictions |
| <input type="checkbox"/> Visitor restrictions | <input type="checkbox"/> Closed units to transfers and admits |
| <input type="checkbox"/> Specimen collection and submission | <input type="checkbox"/> Other: _____ |

Additional Actions and Notifications:

- | | |
|---|---|
| <input type="checkbox"/> Local Health Department | <input type="checkbox"/> MDLARA Bureau of Health Systems |
| <input type="checkbox"/> MDHHS Bureau of Laboratories | <input type="checkbox"/> Federal Agencies: |
| <input type="checkbox"/> MDARD | <input type="checkbox"/> CDC <input type="checkbox"/> FDA <input type="checkbox"/> USDA |
| <input type="checkbox"/> MDHHS Public Information Officer | <input type="checkbox"/> Other: _____ |

This information may be reported to the MDHHS Division of Communicable Diseases by telephone (517) 335-8165 or fax (517) 335-8263