



INITIAL RESPIRATORY OUTBREAK NOTIFICATION FORM

Please complete all applicable areas and **FAX to 613-735-3067**

RCDHU INFORMATION	Date:		Outbreak # 2257- 20__ - __ - __				
	Investigator:		Investigator Telephone #:				
	Date Outbreak Reported to RCDHU (YYYY/MM/DD):						
FACILITY INFORMATION	Facility Name:						
	Facility Type (please check appropriately):			<input type="checkbox"/> LTC	<input type="checkbox"/> Hospital	<input type="checkbox"/> Retirement Home	
	Facility Address:			Facility Telephone #:			
	City:		Postal Code:	Facility Fax #:			
	Primary IPAC Staff Contact:			Primary IPAC Staff Email:			
	Alternate IPAC Staff Contact:			Alternate IPAC Staff Email:			
	Date of Onset of Illness in FIRST CASE (YYYY/MM/DD):						
	Outbreak Description	RESIDENT INFORMATION			STAFF INFORMATION		
		# Residents in facility			# Staff in facility		
		# Resident Cases			# Staff Cases		
		# Residents COVID vaccinated			# Staff COVID vaccinated		
		# Residents FLU vaccinated			# Staff FLU vaccinated		
	Symptoms	Abnormal T °C (> 37.5° or <35.5°)		Headache		Chills	
Swollen/ tender Glands in neck		Loss of Appetite		Sore Throat/ Hoarseness			
Runny nose		Malaise(tiredness)		Nasal Congestion/ Sneezing			
Cough		Myalgia (muscle aches)		Other, Specify:			