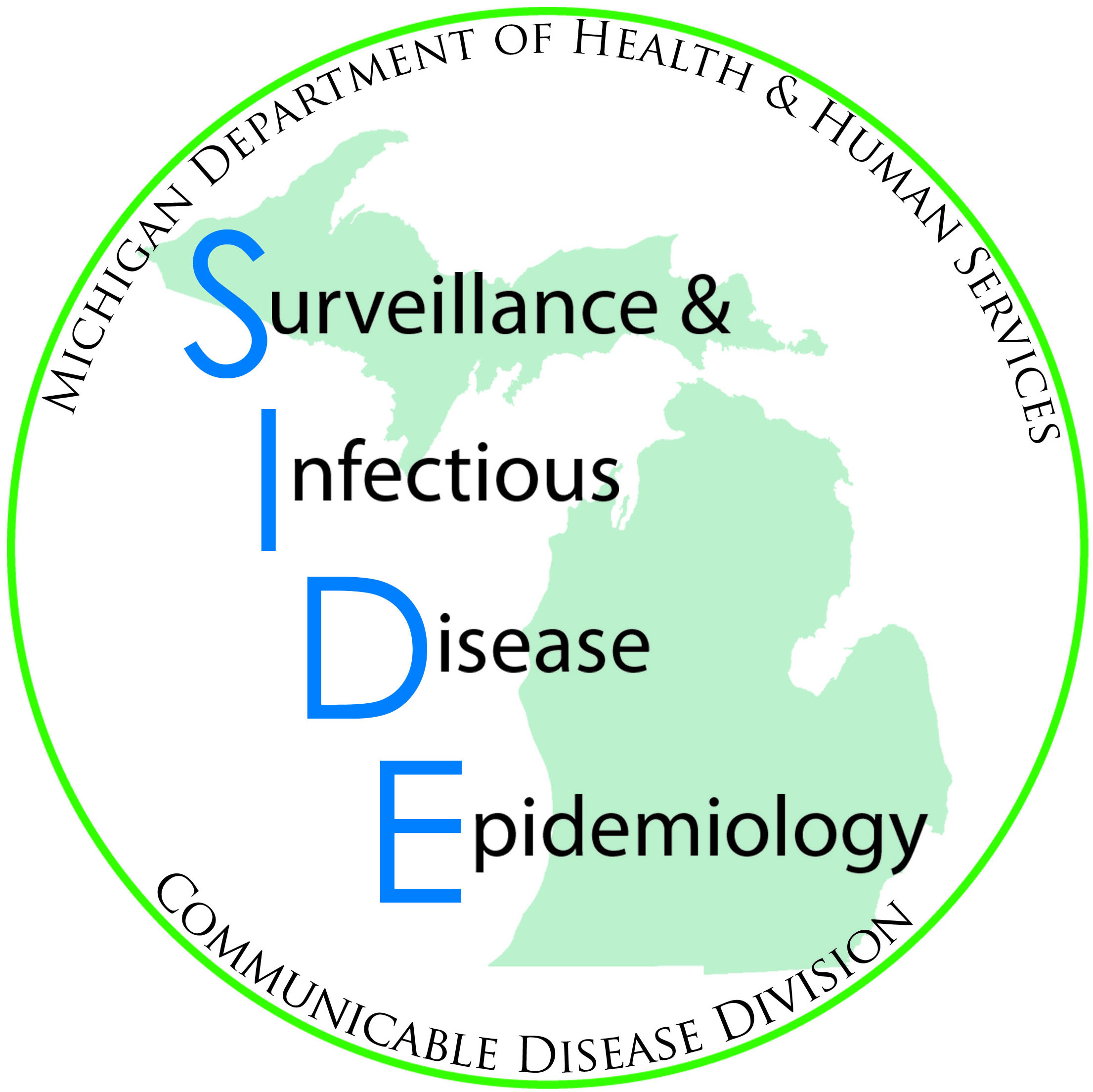
Outbreak Identifier:

County:

Date:

MI Outbreak ID Number:

NORS ID:



□ 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:**

□ Healthcare (Please specify)

□ Acute Care

□ Assisted Living

□ Critical Access

□ Long-term Acute Care

□ Long-term Care/ Nursing Home

□ Outpatient (e.g., dialysis center, ambulatory surgical center)

□ Adult Day Care

□ Child Day Care/ K-12 School

□ Event (e.g., wedding, party, funeral)

□ Restaurant

□ Senior Apartments/ Retirement Center

□ College / University

□ 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 | □ Yes □ No |  |  |
| Diarrhea | □ Yes □ No |  |  |
| Nausea | □ Yes □ No |  |  |
| Abd Cramps | □ Yes □ No |  |  |
| Fever º\_\_\_\_\_\_\_ (highest recorded) | □ Yes □ No |  |  |
| Bloody Stools | □ Yes □ No |  |  |
| Respiratory (e.g., coughing, wheezing) | □ Yes □ No |  |  |
| Pneumonia | □ Yes □ No |  |  |
| Rash | □ Yes □ No |  |  |
| Itching | □ Yes □ No |  |  |
| Skin and soft tissue wound/damage | □ Yes □ No |  |  |
| Other : | □ Yes □ No |  |  |

**Specimen Testing:**

□ Declined

□ Stool- Norovirus

□ Stool - Bacterial

□ Stool - Ovum and Parasites

□ Respiratory Swab/ Secretion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Blood: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Wound/Skin Cultures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Consultation Provided:** Date Prevention and Control Actions Initiated: \_\_\_\_\_\_\_\_\_\_\_\_\_

□ Environmental cleaning guidelines □ Infection control precautions

□ Employee restrictions □ Patient cohorting, isolation, and restrictions

□ Visitor restrictions □ Closed units to transfers and admits

□ Specimen collection and submission □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Actions and Notifications:**

□ Local Health Department □ MDLARA Bureau of Health Systems

□ MDHHS Bureau of Laboratories □ Federal Agencies:

□ MDARD □ CDC □ FDA □ USDA

□ MDHHS Public Information Officer □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information may be reported to the MDHHS Division of Communicable Diseases**

**by telephone (517) 335-8165 or fax (517) 335-8263**