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:

☐ 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

☐ Employee restrictions

☐ Visitor restrictions

☐ Specimen collection and submission

☐ Infection control precautions

☐ Patient cohorting, isolation, and restrictions

☐ Closed units to transfers and admits

☐ Other:_____

Additional Actions and Notifications:

☐ Local Health Department

☐ MDHHS Bureau of Laboratories

☐ MDARD

☐ MDHHS Public Information Officer

☐ MDLARA Bureau of Health Systems

☐ Federal Agencies:

☐ CDC ☐ FDA ☐ USDA

☐ Other:_____

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