Gastrointestinal Outbreak Report Form
Institutional Facility

Date of Report: _____ /_____ /_____ **Time:** _____:_____ AM/PM

Facility Contact's Name: _____ **Contact's Position:** _____

Telephone # of Contact: _____-_____-_____ **Fax # of Contact:** _____-_____-_____

Alt. Contact's Name: _____

Facility Name: _____ **County:** _____

Mailing Address: **Street Address:**

_____ _____

_____ _____

General Symptoms of Illness:

☐ Nausea ☐ Vomiting ☐ Diarrhea

☐ Abdominal pain ☐ Headache ☐ Bloody diarrhea

☐ Fever _____°F ☐ Muscle aches ☐ Chills

☐ Other _____

First Resident Case: _____ /_____ /_____ **First Staff Case:** _____ /_____ /_____

Last Resident Case: _____ /_____ /_____ **Last Staff Case:** _____ /_____ /_____

Average Duration of Illness (avg. length of time for individual resident illness)**:** _____ (hours, days)

Wing(s)/Hall(s) Affected: _____

Total Residents at Facility: _____ **Total Residents Ill with GI Illness:** _____

Anyone hospitalized related to outbreak? ☐ Yes ☐ No
If yes, details _____

Any deaths related to outbreaks? ☐ Yes ☐ No
If yes, details _____

Total Staff Employed at Facility: _____ **Total Staff Ill with GI Illness:** _____

Any sick food handlers?: ☐ Yes ☐ No If yes, details_____

Does facility share staff with other LTCFs? ☐ Yes ☐ No
If yes, details_____

Stool specimens submitted to GPHL ☐ Yes ☐ No
Number viral (fresh stool)_____Number bacterial (Para-Pak)_____
Test results_____