Kentucky Department for Public Health

GI/Oubreak Surveillance Form (Staff/Employees)

Facility: | Contact Person:

Date of Onset for INDEX case: | **Date Outbreak Identified:**

CASE DEFINITION: ex: Any resident or staff member working at facility in , who has had (including on going) at least 2 or more episodes of vomiting and or diarrhea in 24 hour period between xxx-x - 2013 to xxx- xx - 2013.

		Resident						Illness									
No:	Name	Gender	DOB (M/D/Y)	Age	Room #/ Address	Room Type/City, State	Onset Date	Onset Time	Vomiting Yes/No	# of Vomiting Episodes/24 hrs	Diarrhea Yes/No	Bloody Diarrhea Yes/No	# of Diarrhea Episodes/24 hrs	Fever Yes/No	If fever: Max Temp	List other Symptoms**	Symptom Duration (Days)
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					Telephone:					
					Date Outbreak Notified to Health Department:					
				Case	Specimen					
No:	Name	Healthcare Provider Visit Yes/No	Hospitalized Yes/No	Yes/No	Specimen Source	Collection Date	Date Submitted	Result	Organism	
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