Kentucky Public Health
Prevent. Promote. Protect.

Final Reporting Form for Outbreaks

General Information			
Outbreak Number:	KY_____-_____	**Today's Date:**	
County:		**Region:**	
Local Health Department:			
Primary contact person for epidemiologic investigation:		**Telephone:**	
		Email:	
LHD Nurse (if different from above):		**Telephone:**	
		Email:	
LHD Environmentalist (if different from above):		**Telephone:**	
		Email:	
Regional Epidemiologist (if different from above):		**Telephone:**	
		Email:	

Facility/Establishment Information	
Is outbreak associated with an event?	☐ Yes ☐ No Describe event: _____ _____
Is outbreak associated with a facility?	☐ Yes ☐ No
Facility/Establishment Name (if applicable):	
Outbreak Setting Type:	

☐ Long-term Care (e.g., assisted living, skilled nursing, etc.), specify: _____
☐ Outpatient Care (e.g., clinic, dialysis, etc.), specify: _____
☐ Hospital (e.g., acute care, inpatient psychiatry, etc.), specify: _____
☐ Restaurant (e.g., fast food, sit-down, etc.), specify: _____
☐ Daycare/Preschool/Early Childhood Education, specify: _____
☐ School (K-12), specify grade(s): _____
☐ Prison/Correctional Facility, specify: _____
☐ Other, specify (e.g., camp, church, residence, etc.): _____

Facility/Establishment Contact Person:				**Phone Number:**	
Facility/Establishment Location:				**Fax Number:**	
City:		**County:**		**Zip Code:**	

Counties Where Cases Reside:	

Illness Characteristics			
Predominant Symptoms (check all that apply):			
Gastrointestinal (GI)	**Respiratory (e.g., RSV)**	**Hand, Foot, and Mouth (HFM)**	**Dermatological (e.g., Scabies)**
☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Abdominal Cramps	☐ Runny Nose ☐ Decreased Appetite ☐ Coughing ☐ Sneezing ☐ Wheezing	☐ Mouth Sores ☐ Skin Rash, specify: _____	☐ Pruritus (i.e., itching) ☐ Papular Itchy Rash
☐ Fever, specify maximum temperature: _____ ☐ Other Symptoms, specify: _____			
Average Incubation Period: (specify hours or days)		**Median:**	
Average Duration of Illness: (specify hours or days)		**Median:**	
Outbreak Etiology:	☐ Norovirus / Gastrointestinal (GI) Unknown ☐ Salmonellosis ☐ Shiga toxin-producing *Escherichia coli* (STEC) ☐ Respiratory Syncytial Virus (RSV) ☐ Hand, Foot, and Mouth (HFM) ☐ Scabies ☐ Varicella / Chicken Pox ☐ Healthcare-Associated Infection (HAI) ☐ Other, specify: _____		
Treatment Information *(optional)*:			
Vaccination Status *(optional)*:			

Outbreak Information			
Onset date of first case:	____/____/_____	**Onset date of last case:**	____/____/_____
Date LHD Notified:	____/____/_____		

Case Classification:

Case Definition:

Investigation Methods:

Case Counts:

Number of Cases:		**Estimated Number of Cases (if exact number unknown):**	
Male:		**Percent Male:**	
Female:		**Percent Female:**	
Unknown:		**Percent Unknown:**	

Number of Primary Cases:		**Number Died as Result of Infection:**	
Number of Secondary Cases:		**Number Hospitalized:**	
Number of Tertiary Cases:		**Number Visited Emergency Room:**	
Number with information available:		**Number Visited Health Care Provider:**	

Facility-Associated and Other Congregate Setting Outbreaks *(optional)*

Attack Rates:

Number of ill residents/persons (x_1)		**Total Number of Residents/Exposed Persons (y_1)**	

Resident Attack Rate % (x_1/y_1) x 100		%	
Number of ill staff/persons (x_2)		**Total Number of Staff Employed at the Facility (y_2)**	
Staff Attack Rate % (x_2/y_2) x 100		%	
Number of Residents/Persons Admitted to the Hospital:		**Number of Staff Admitted to the Hospital:**	
Number of Residents/Persons seen by a Healthcare Provider:		**Number of Staff seen by a Healthcare Provider:**	
Number of Residents/Persons who have died:		**Number of Staff who have died:**	

Laboratory Information			
Were any specimens collected for testing?	☐ Yes ☐ No	**Number of Specimens:**	
Specimen Type(s):			
Lab Test Results:			
Lab Testing Conducted by: **(e.g., LabCorp, DLS, etc.)**			
Comments:			

Control Measure Information
Infection Control Recommendations: (Describe actions taken to limit the spread of illness to others)
Environmental Assessment Information: (Describe findings of Environmental Assessment, if conducted. Include any recommendations made by Sanitarian during the assessment.)

Analysis of Outbreak Response
Strengths:
1.
2.
3.
Areas for Improvement:
1.
2.
3.

Additional Comments:
Epidemic Curve
National Outbreak Reporting System (NORS) Report
Enter NORS-reportable outbreak reports to NORS within 60 days of the outbreak being declared over. Please contact the Reportable Disease Section at the Kentucky Department for Public Health if you need assistance.
Please send a copy of this completed form to the Reportable Disease Section at the Kentucky Department for Public Health.