

ACUTE RESPIRATORY ILLNESS OUTBREAK FOLLOW-UP

Name of facility: _____	
City: _____	County: _____
Health Department Jurisdiction: _____	

Laboratory confirmed diagnosis (indicate all that pertain)

Influenza A _____ Influenza B _____ Parainfluenza _____
 Adenovirus _____ RSV _____ Human Metapneumovirus _____
 Rhinovirus _____ Other (specify) _____

Onset date of first respiratory illness _____

Onset date of last respiratory illness _____

	Number exposed	Number ill	Number hospitalized	Number of deaths
Residents	_____	_____	_____	_____
Staff	_____	_____	_____	_____

Complete section below for suspected or confirmed influenza outbreaks only.

Influenza Prophylaxis

Was an antiviral administered to exposed individuals? Y____ N _____

If yes, please indicate product: _____

Number of residents who received antiviral prophylaxis _____

Number of staff who received antiviral prophylaxis _____

Vaccination	Total number at facility	Total number that received Influenza vaccine	Number ill that received Influenza vaccine
Residents	_____	_____	_____
Staff	_____	_____	_____

With what influenza vaccine were residents vaccinated? If response is "yes" to more than one vaccine specify the percentage of total vaccinated for each

	Y	N	_____ %	Date(s) administered
Fluzone	_____	_____	_____ %	_____
Fluzone high-dose	_____	_____	_____ %	_____
Fluzone intradermal	_____	_____	_____ %	_____
Fluvirin	_____	_____	_____ %	_____
Fluarix	_____	_____	_____ %	_____
Flulaval	_____	_____	_____ %	_____
FluMist	_____	_____	_____ %	_____
Unknown	_____	_____	_____ %	_____

Please return this form to the Wisconsin Bureau of Communicable Disease and Emergency Response by either e-mail Thomas.haupt@wi.gov or secure fax to (608) 261-4976.