

COVID-19 Long Term Care Outbreak Line Listing: Resident

Date: _____ (update each day)

Outbreak #: _____

This resident line list is **cumulative**. Review and update the list daily and fax to **705.677.9618 by 10:00 a.m.** Please consider a respiratory or enteric outbreak if residents have common symptoms and exposure location. Use the [respiratory](#) or [enteric](#) outbreak line list for reporting. These forms are available at [phsd.ca](#)

Demographics				Check all that apply (specify where applicable)										COVID-19 test		Additional information				
Name	DOB (yyyy/mm/dd)	Gender	Room number	Date symptoms started (yyyy/mm/dd)	Cough (new or worse)	Fever/abnormal temp (indicate temperature)	Fatigue/ malaise/ lethargy	Nose: congestion/ runny/ sneezing	Throat: sore/ hoarse/ difficulty swallowing	Shortness of breath	Nausea/ Vomiting/ abdominal pain/ diarrhea	Change in taste or smell	Other (delirium, falls, sudden decline, tachycardia, decreased BP, hypoxia, etc.)	Asymptomatic close contact (initials of symptomatic ind.)	Asymptomatic other (return from hospital/apt etc.)	Date tested (yyyy/mm/dd) If not tested, specify why	Result	Isolation start date (yyyy/mm/dd)	Isolation end date (yyyy/mm/dd)	Date symptoms resolved (yyyy/mm/dd)

