

COVID-19 Long Term Care Outbreak Line Listing: Staff

Date: _____ (update each day)

Outbreak #: _____

This staff 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](#)

| Facility: | | | | Wing/ area/ floor: | | | | Contact person: | | | | Tel: | | Fax: | | | | |
|--------------|----------------|--|------------------------------|---|----------------------|--|----------------------------|-----------------------------------|---|---------------------|--|--------------------------|-----------------------|---|--|--------|-------------------------------------|----------------------------------|
| Demographics | | | | Check all that apply (specify where applicable) | | | | | | | | COVID-19 test | | Additional information | | | | |
| Name | DOB yyyy/mm/dd | Work location within the facility and role | Last day worked (yyyy/mm/dd) | 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: Please specify | Asymptomatic close contact (initials of symptomatic ind.) | Date tested (yyyy/mm/dd) If not tested, specify why | Result | Date symptoms resolved (yyyy/mm/dd) | Return to work date (yyyy/mm/dd) |
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