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 chemoprophylaxis administered to exposed individuals? Y___ N ____

If yes, please indicate product: _____

Number of residents who received chemoprophylaxis _____

Number of staff who received chemoprophylaxis _____

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

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

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.