COVID-19 OUTBREAK DAILY UPDATE FORM

Please send daily to YRPH and include this completed form each time a line list is submitted by fax (905-762-2119) or secure FTP site. For more questions, please contact your assigned investigator.

Outbreak #:		
Facility name:		
Facili	ity Response:	
Today's date:		
Name and contact details of individual completing		
daily update form and line list:		
Total # of line list pages:		
Today's	s Key Concerns:	
No con	cerns today: 🗆	
Concerns identified (e.g. staffing concerns,		
IPAC, PPE supplies, PPE breaches, etc.):		
Line List U	pdates for Today:	
No changes t	today to the line list: □	
Any changes to today's line list:		
 Please indicate any new cases, new 		
symptomatic individuals,		
hospitalizations and deaths with		
corresponding line list page number		
and line list client number		
Cumulative (Total) Counts:	Resident	Staff
Total # of COVID-19 cases	Resident	Stair
Total # of COVID-19 related deaths		
Total # of COVID-19 hospitalizations		
Please ensure that each new hospitalization and deat	l h are recorded in the Hosnitali	zation and Death Outhreak chart
and faxed and included in the line list.	n are recorded in the riospitali	zacion ana Beach Gatbreak chare
	recautions in Place:	
Last IPAC inspection date:		
Units/floors on droplet contact precautions:		
Tesi	ting Details:	
Next surveillance testing date(s):		
•	Resident	Staff
# of pending surveillance tests:		
# of pending case/contact tests:		
Vaccir Vaccir	nation Details:	
Vaccir Next immunization date(s):	nation Details:	
	nation Details: Resident	Staff



COVID-19 Respiratory Outbreak Line list: Please complete and fax (905-762-2119) to York Region Public Health before noon each day. Page ___ out of ____ Institution Name: Date outbreak Declared: Outbreak number: 2270- 20____-Residents or staff?

Resident List Staff List Visitor List Facility representative name and contact information: Case Identification Reason for testing Comments Symptoms - when assessing for symptoms, evaluate whether they are new, worsening immuniz mm-dd) Please include additional relevant details and ame (LAST NAME, first name) clearance/return to work date

 ${\bf *Atypical\ signs\ and\ symptoms:\ chills,\ headache,\ conjunctivitis,\ fatigue, malaise,\ myalgias}$

For more details on COVID related symptoms, see provicinal guidance

This information is being collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c.H.7 for the purpose of outbreak investigation, monitoring, management and follow-up; infectious disease surveillance; public health administration and the provision of statistical data to the Ministry of Health and Long Term Care information will be retained, used, disclosed and disposed of in accordance with the Personal Health Information Protection Act, 2004, C.3. If you have received this facsimile in error, or if you have received this facsimile in error, or if you have any questions, please contact the Management at ext. 73588

Last update: 2021-11-09

C	COVID-19 Respiratory C Institution Name: Outbreak number: 2270- 20_				t: Ple	ase co	omple 	te and	d fax (905-7	62-21	.19) to	Floor/						_			each		Da			eclared: Itative na		nd conta	ect infor	mation:			Page out of
					Case Ider	ntification												Rea	son fo	or testing	g						Specii	men			t/ Contact	Out	come	Comments
Ī			n date	ation	uoj				ome, or	ū	irmed	Sta	aff	Symptoms				nptoms,	evaluat		er they		worseni	ing,	ients)					1100	(pp-		Come	comments
	Name (LAST NAME, first name)	Health Card Number	First COVID immunization (yyyy-mm-dd)	Second COVID immuniz dates (yyyy-mm-dd)	Third COVID immunizat dates (yyyy-mm-dd)	Seasonal Influenza Immunization Date (yyyy-mm-dd)	Floor/room number	DOB (yyyy-mm-dd)	Transfer from facility, ho hopsital	Roomate of symptomatic resident	High risk contact of confirm case	Position Role	last day worked, last unit worked	Onset date of first symptom (vxxx-mm-dd)	(yyyy	New/worsening cough	Shortness of breath	Loss of taste / smell	Runny/Stuffy/ congested nose	Sore throat	Loss of taste or smell	Nausea / Vomiting / Diarrhea	Abdominal Pain	Symptoms*	Asymptomatic (please specify in comm	NP swab collection date (yyyy-mm-dd)	COVID results (Pos/Neg/Ind/Pending)	Influenza Result (Pos/Neg INT)	Other Causitive Agents	initiated (yyyy-mm-dd)	Discontinued (уууу-тт	Hospitalized date (yyyy-mm-dd) and details	Death (yyyy-mm-dd)	Please include additional relevant details and clearance/return to work date

*Atypical signs and symptoms: chills, headache, conjunctivitis, fatigue, malaise, myalgias

For more details on COVID related symptoms, see provicinal guidance

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				Case Iden	ntification											Rea	son for	r testin	σ					Spec	imen			t/ Contact	Out	come	Comments
(Algertham of the control of the con	Health Card Number	First COVID immunization date (yyyy-mm-dd)	Second COVID immunization dates (yyyy-mm-dd)	ation			БОВ (уууу-тт-dd)	Transfer from facility, home, or hopsital	Roomate of symptomatic resident	High risk contact of confirmed case	Position Role	ed, last	Onset date of first symptom (vww.mm-dd)	or		nptoms, le individ	evaluate		er they nealth st		Other/Atypical 'bun's' Symptoms*	Asymptomatic (please specify in comments)	NP swab collection date (yyyy-mm-dd)		Influenza Result (Pos/Neg INT)	Other Causitive Agents	initiated (yyyy-mm-dd)	Discontinued (yyyy-mm-dd)	Hospitalized date (yyyy-mm-dd) and details	Death (yyyy-mm-dd)	Please include additional relevant details and clearance/return to work date

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COVID Outbreak Manag	gement for Institutions
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nstitution Name:					
Outhreak number: 2270- 20	_				

Hospitalization and Death Chart

Page	out	of	

Note: The intent of this chart is to track hospitalizations and deaths throughout the duration of the outbreak. For each new hospitalization or death, facilities should keep this chart up to date as the details below become available.

	Demographics				Hospitalization	Death						
Room number	Resident / patient	Date of birth (yyyy/mm/dd)	Admission date (yyyy/mm/dd)	Name of hospital	Reason for hospitalization	Admitted to ICU (yyyy/mm/dd)	Outbreak related (Y/N)	Date of discharge (yyyy/mm/dd)	Date of death (yyyy/mm/dd)	Cause of death	Outbreak related (Y/N)	Post mortem swab collected (Y/N)

- Toronto General Hospital - Branson Ambulatory Care Centre - Princess Margaret Hospital List of Hospitals - Toronto Western Hospital - Royal Victoria Regional Health Centre - Hospital for Sick Children - Cortellucci Vaughan Hospital - Trillium Health Centre West Park - Mackenzie Health Richmond Hill Hospital - Humber River Regional Hospital - Scarborough & Rough Hospital (specify site) (specify site) Hospital - Markham Stouffville Hospital - William Osler Hospital - Michael Garron Hospital - Sunnybrook Health Sciences Centre - Southlake Regional Hospital (specify site) - Mount Sinai Hospital - St. Michael's Hospital - Women's College Hospital - North York General Hospital - St. Joseph's Health Sciences Centre