Line Listing of Residents - Respiratory Outbreak or Increased Incidence of ILI Symptoms (For Resident/Patient Cases)

Facility								**Laboratory**		**Case Category**	**Outcomes related to Outbreak**									**Outcomes unrelated to Outbreak** LTC Facilities Only							
Unit/Floor																											
Entry Date *(dd-mmm-yyyy)*	**Last Name**	**First Name**	**PHN/MRN**	**Age**	**Sex M/F**	**Patient's Room Number** *(when symptoms began)*	**Flu Vaccine past 12 months**	Lab sample submitted	Date sample submitted *(dd-mmm-yyyy)*	Confirmed, Probable, or Not a Case	Onset Date *(dd-mmm-yyyy)*	Fever	Cough	Sore Throat	Painful Joints	Muscle Pain	Headache	Prostration	Resolu-tion Date *(dd-mmm-yyyy)*	Hospitalized	Transferred to another unit	Discharged	Died	Hospitalized	Died	**Comments**

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Facility								**Laboratory**		**Case Category**	**Outcomes related to Outbreak**									**Outcomes unrelated to Outbreak** Residential Facilities Only						
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Entry Date *(dd-mmm-yyyy)*	**Last Name**	**First Name**	**PHN/MRN**	**Age**	**Sex M/F**	**Patient's Room Number** *(when symptoms began)*	**Flu Vaccine past 12 months**	Lab sample submitted	Date sample submitted *(dd-mmm-yyyy)*	Confirmed, Probable, or Not a Case	Onset Date *(dd-mmm-yyyy)*	Fever	Cough	Sore Throat	Painful Joints	Muscle Pain	Headache	Prostration	Resolu-tion Date *(dd-mmm-yyyy)*	Hospitalized	Transferred to another unit	Discharged	Died	Hospitalized	Died	**Comments**