*\*FAX COMPLETE FORM AND LINE LIST TO WAUKESHA COUNTY HEALTH DEPT:* ***262-896-8387***

*\*PLEASE FAX ANY POSITIVE LAB RESULTS APPLICABLE TO OUTBREAK*

|  |
| --- |
| DATE: |
| FACILITY NAME: |
| facility address: |
| Telephone #: |
| Fax #: |
| contact person: |
| email: |

LABORATORY CONFIRMED DIAGNOSIS (INDICATE ALL THAT PERTAIN):

|  |  |  |
| --- | --- | --- |
| NOROVIRUS | C.DIFF | SHIGA-TOXIN E.COLI |
| SAPOVIRUS | SALMONELLA | CAMPYLOBACTER |
| ASTROVIRUS | OTHER (SPECIFY): | |

**NAME OF UNIT:**

**ONSET DATE OF FIRST GI ILLNESS FOR RESIDENTS:**

**ONSET DATE OF FIRST GI ILLNESS FOR STAFF:**

**ONSET DATE OF LAST GI ILLNESS FOR RESIDENTS:**

**ONSET DATE OF LAST GI ILLNESS FOR STAFF:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | NUMBER EXPOSED | NUMBER ILL | NUMBER HOSPITALIZED | NUMBER OF DEATHS |
| RESIDENTS: |  |  |  |  |
| STAFF: |  |  |  |  |

NAME OF UNIT:

**ONSET DATE OF FIRST GI ILLNESS FOR RESIDENTS:**

**ONSET DATE OF FIRST GI ILLNESS FOR STAFF:**

**ONSET DATE OF LAST GI ILLNESS FOR RESIDENTS:**

**ONSET DATE OF LAST GI ILLNESS FOR STAFF:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | NUMBER EXPOSED | NUMBER ILL | NUMBER HOSPITALIZED | NUMBER OF DEATHS |
| RESIDENTS: |  |  |  |  |
| STAFF: |  |  |  |  |

*\*If there are additional units affected, please add an additional page containing that information.*