New Jersey Department of Health
Communicable Disease Service

OUTBREAK REPORT FOR LONG TERM CARE AND OTHER INSTITUTIONS

Name of Lead Public Health Agency	County	E#

Date Outbreak Reported to Local Health Department (LHD):	Date Outbreak reported to Regional Epidemiologist:	Date Outbreak Reported to State Health Department

BRIEF SUMMARY

FACILITY INFORMATION

A. FACILITY DESCRIPTION

Name of Facility	Telephone Number
Street Address	County
City/Town	Zip Code
Name of Contact Person	Contact Telephone Number
Title	Contact Fax Number

Type of Facility/Population *(check all that apply)*:

☐ Nursing home ☐ Sub-acute care, adult ☐ Sub-acute care, pediatric
☐ Assisted living ☐ Group home, adult ☐ Group home, pediatric
☐ Independent living ☐ Hospice ☐ Other *(specify)*: _____

Total Number of Beds

State the number of buildings, wings, units, floors, etc. that make up the facility. Include number and describe type of residents per area (e.g., do the residents have dementia, require skilled care, etc.).

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(Continued)

B. OUTBREAK DEMOGRAPHICS

Residents:	Total Number (Census):	Number Ill:	Number Hospitalized:	Number Deaths:
Staff: *	Total Number:	Number Ill:	Number Hospitalized:	Number Deaths:

** Staff includes volunteers, private duty, contracted or agency personnel who perform patient care, housekeeping, recreational, laundry, dietary, social service and administrative activities.*

Specify location of outbreak within physical structure described above. Attach floor plan and identify affected area(s):

Illness Onset Date – FIRST Case	Illness Onset Date – LAST Case

Type of Illness

☐ GI ☐ Respiratory/ILI ☐ Influenza ☐ Other *(specify)*: _____

Duration of Illness
(e.g., 24-48 hours, 1-5 days)

Signs and Symptoms (check all that apply and document % of cases for each):

X	%	Sign or Symptom	X	%	Sign or Symptom	X	%	Sign or Symptom
☐	_____	Abdominal cramps	☐	_____	Diarrhea	☐	_____	Nausea
☐	_____	Bloody stool	☐	_____	Fatigue	☐	_____	Pneumonia
☐	_____	Chest pain	☐	_____	Fever	☐	_____	Shortness of breath
☐	_____	Chills	☐	_____	Headache	☐	_____	Sneezing
☐	_____	Cough, productive	☐	_____	Malaise	☐	_____	Sore throat
☐	_____	Cough, non-productive	☐		Nasal congestion	☐	_____	Vomiting

Other *(Specify)*:

☐ _____ _____

☐ _____ _____

☐ _____ _____

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OUTBREAK INVESTIGATION

A. INVESTIGATION TEAM

Representative's Position	Name/Title	Telephone Number
Facility		
Local Health		
LINCS/Regional		
NJDOH		
Other *(Specify)*		

B. OUTBREAK CASE DEFINITION

C. MODE OF TRANSMISSION

☐ Foodborne ☐ Person to Person ☐ Waterborne ☐ No Source Identified
☐ Other *(specify)*: _____

D. LABORATORY TESTING

☐ No Specimens Obtained ☐ Specimens Obtained; Findings as follows:

Specimen Type (e.g., stool, food item, environmental/other, please specify)	Test Requested	Name of Testing Site	Number Positive/ Number Negative	Positive Findings (e.g., Norovirus, Influenza A, etc.)

Did PHEL validate lab testing done on-site or at hospital/commercial lab? ☐ No ☐ Yes	Outbreak Causative Agent

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E. CONSULTATION/INVESTIGATION: TYPE AND FINDINGS

Health Officer: On-site evaluation? ☐ No ☐ Yes

Name: _____ Title: _____

Public Health Nurse: On-site evaluation? ☐ No ☐ Yes

Name: _____ Title: _____

Registered Environmental Health Specialist: On-site evaluation? ☐ No ☐ Yes

Name: _____ Title: _____

Epidemiologist: On-site evaluation? ☐ No ☐ Yes

Name: _____ Title: _____

Other *(specify)*: _____: On-site evaluation? ☐ No ☐ Yes

Name: _____ Title: _____

CONTROL MEASURES

Describe Control Measures Implemented	Date Instituted	Date Reinforced	Date Suspended
Closed to admissions (new and readmits):			
Cohort Residents:			

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CONTROL MEASURES			
Describe Control Measures Implemented	**Date Instituted**	**Date Reinforced**	**Date Suspended**
Cohort Staff:			
Cohort Equipment:			
Cohort Supplies:			
Institute Contact Precautions:			
Institute Respiratory Precautions:			
Provide Mandatory In-service Education to All Staff:			
Reinforce Standard Precautions (Staff and Residents):			
Restrict Movement within Facility:			
Restrict Visits from Family, Friends and Volunteers:			
Post Signs to Enforce Infection Control Measures:			
Provide Adequate Supplies of Gowns/Gloves at Residents' Rooms:			
Environmental Measures:			
Other (Specify):			

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(Continued)

DOCUMENTATION
Documents Attached to this Outbreak Summary *(check all that apply)*:
☐ Epidemic Curve (required) ☐ Line-Listing (required)
☐ REHS Facility Inspection report ☐ Floor Plan
☐ Lab Test Reports ☐ Foodborne Outbreak Summary Form
☐ Waterborne Outbreak Summary Form ☐ Other *(specify)*: _____

OUTCOME
Date Outbreak Resolved (i.e., control measures lifted):
Recommendations for Future Actions (e.g., revised protocol, developed new protocol, changed product use, etc.):

COMPLETED BY
Name: _____ Title: _____
Agency: _____
Phone: _____ Fax: _____
Email: _____