

RESPIRATORY LINE LISTING

Facility Name:	Total # staff / resident in facility: _____ / _____
Unit Name:	Total # staff / resident on unit : _____ / _____
IF APPLICABLE: Outbreak Number #2244/2023/_____ Potential Declared (yy/mm/dd): _____ Active Declared (yy/mm/dd): _____	
<input type="checkbox"/> resident line list <input type="checkbox"/> staff line list	

Personal Data		Symptoms (new or worsened)													Testing				Outcomes				Comments							
		Atypical presentations should be considered, particularly in elderly persons: fatigue/malaise, altered mental status, falls, acute functional decline, chills, headache, croup, unexplained tachycardia and hypoxia, decrease in blood pressure													COVID-19		Resp Panel		Isolation				Hospital	Died						
#	Name/Age/DOB/ Ontario Health Card Number	Room	Unit	Onset yy/mm/dd	Fever	Cough (P – productive, D- dry)	SOB	Runny nose (R) Sneezing (S)	Sore Throat (S) Difficulty Swallowing (D) Hoarse Voice (H)	Nausea (N) Vomiting (V)	Diarrhea	Abdominal pain	New olfactory or taste disorder	Pneumonia C-clinical R-radiological	Atypical Presentation (see above; please specify)	Additional symptoms	Meets suspect case	Meets case	Swabbed yy/mm/dd	Results yy/mm/dd	Swabbed yy/mm/dd	Results yy/mm/dd	Date in yy/mm/dd	Date out yy/mm/dd			ER or admitted DX yy/mm/dd	yy/mm/dd		

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															COVID-19		Resp Panel		Isolation		Hospital			Died					
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