

## **Enteric Outbreak Summary and Epi-Curve**

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|      |    |

| Outbreak Number Inves |        |       |  |  | nvestigator: |   |  |   |                    |   |    |       | Name of Facility: |  |   |  |                            |                       |                      |        |  |     | Lab Confirmation Date: |                      |          |    |   | Lab Confirmation Date: |          |  |  |  |
|-----------------------|--------|-------|--|--|--------------|---|--|---|--------------------|---|----|-------|-------------------|--|---|--|----------------------------|-----------------------|----------------------|--------|--|-----|------------------------|----------------------|----------|----|---|------------------------|----------|--|--|--|
| 3895                  |        |       |  |  |              |   |  | Outbreak Areas:                                 |                    |   |    |       |                   |  |   |  |                            | Or                    | Organism Identified: |        |  |     |                        | Organism/Identified: |          |    |   |                        |          |  |  |  |
| Notific               | cation | Date: |  |  |              |   |  |   |                    |   | То | day's | Date:             |  |   |  |                            |                       |                      |        |  | - 1 |                        |                      |          |    | 1 |                        |          |  |  |  |
| Case Definition:      |        |       |  |  |              |   | Resident = R / Patient = P Staff = S R / P S |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        | Related to OB        |          |    |   |                        |          |  |  |  |
|                       |        |       |  |  |              |   | ff = S                                       | 1 - 4'  | -4 -: -1           | _ |    | K/    | R/P S             |  |   |  | I I a a side lier add a si |                       |                      |        |  |     |                        | S                    |          |    |   |                        |          |  |  |  |
|                       |        |       |  |  |              |   |  | Total Population at risk                        |                    |   |    |       |                   |  |   |  |                            | Hospitalization Death |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
|                       |        |       |  |  |              |   |  | Pop at risk in outbreak area/s Total Number ill |                    |   |    |       |                   |  |   |  |                            | Other:                |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
|                       |        |       |  |  |              |   |  |   | Total Nulliber III |   |    |       |                   |  |   |  |                            |                       |                      | Other: |  |     |                        |                      |          |    |   |                        |          |  |  |  |
| S                     |        |       |  |  |              |   |  | -   | <u> </u>           | - |    | _     |                   |  |   |  |                            |                       |                      |        |  | _   | _                      | _                    | <u> </u> |    |   |                        |          |  |  |  |
| R / P<br>Total        |        |       |  |  |              |   |  | 1   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     | _                      | 4                    |          |    |   |                        |          |  |  |  |
| Total                 |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
|                       |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
|                       |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
|                       |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        | +        |  |  |  |
| S                     |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
| Number of Cases       |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
| of (                  |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
| per                   |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
| l m                   |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
| Z                     |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          | 1  |   |                        | <u> </u> |  |  |  |
| ,                     |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        | <u> </u> |  |  |  |
|                       |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
|                       |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
| Date<br>mm /<br>dd    |        |       |  |  |              |   |  |   |                    |   |    |       |                   |  |   |  |                            |                       |                      |        |  |     |                        |                      |          |    |   |                        |          |  |  |  |
|                       | ments: |       |  |  |              | l | 1  |   |                    |   | 1  |       | l                 |  | l |  | l                          |                       |                      |        |  |     |                        |                      |          | _1 |   | 1                      |          |  |  |  |