



PRELIMINARY REPORT OF INFECTIOUS DISEASE and/or OUTBREAK FORM
E-MAIL this form to HCSPublicHealth@cdcr.ca.gov
If no E-mail: FAX to 916-323-1658 or
916-445-1597 – if the FAX above does not go through.

REPORTING INSTITUTION INFORMATION			
<i>Reporter Name and Title</i>		<i>Institution</i>	
<i>Date</i>		<i>Telephone Number of Reporter ()</i>	
<i>City/County Where Outbreak Located</i>		<i>Email Address of Reporter</i>	
<i>Notified HCM and CMO or Designee</i> ___ Yes ___ No Name(s) (who)		<i>Notified DON or Designee</i> ___ Yes ___ No Name (who)	
		<i>Was Regional PHN II or PHU MD notified?</i> ___ Yes ___ No	
		<i>Was Regional MD or Regional DON notified?</i> ___ Yes ___ No	
DO YOU WANT TO HAVE A CONFERENCE CALL ABOUT THIS CASE? ___ Yes ___ No IF SO, WHEN: _____ DO YOU WANT TO SPEAK TO THE REGIONAL PHN II? ___ Yes ___ No DO YOU WANT TO SPEAK TO THE PHYSICIAN ON CALL? ___ Yes ___ No			
OUTBREAK PRELIMINARY INFORMATION TO DATE			
<i>Type of outbreak</i> ___ STD ___ TB ___ Other Respiratory ___ Skin-Related (e.g. VZV, MRSA, Scabies/Lice) ___ Meningitis ___ Gastroenteritis/Jaundice (e. g. Norovirus, Foodborne, Hepatitis) ___ Unknown ___ Other _____			___ Single Case ___ Multiple Cases
<i>Disease, or Pathogen</i> _____		___ Suspected ___ Confirmed	
<i>Major signs and symptoms:</i> ___ fever ___ cough ___ myalgia ___ weight loss ___ night sweats ___ fatigue ___ nausea ___ vomiting ___ diarrhea ___ rash OTHER (describe): _____			
<i>First Onset Date</i> ___/___/___	<i>Latest Onset Date (so far)</i> ___/___/___	<i>Was lab ordered?</i> ___ <i>How many sent?</i> ___	<i>Sent to which Lab:</i> <i>Public Health (name)</i> _____ <i>Other (name)</i> _____
<i>Number Confirmed Cases</i> _____	<i>Number Suspect Cases</i> _____	<i>Number Hospitalized</i> _____	<i>Number Died</i> _____
CASE INFORMATION			
<i>Setting Type (check all that apply):</i> _ Dormitory housing ___ GACH _ Single cell ___ OHU _ Double cell ___ CCF _ Day room ___ CTC _ Gym housing _ Camp setting _ Other (list) _____		<i>Extent of Outbreak:</i> _ Single Housing Unit _ Multiple Housing Units on Same Yard _ Multiple Yards Involved _ Other _____	<i>Case(s) Characteristics (check all that apply):</i> _ Culinary Worker/Food Handler _ Patient Care Area Porter _ Dormitory Porter _ Laundry Worker _ Fire Fighter _ Other _____ <i>Precautions:</i> _ Airborne _ Contact _ Droplet <u>Isolation?</u> ___ No ___ Yes, and if yes: ___ is in CTC/OHU ___ is out to Hospital ___ is CTQ in cell
ADDITIONAL INFORMATION (Include housing unit(s)/Yard(s) and number of cases where index case and/or exposure case(s) are located)			
PLAN OF ACTION (next steps)			