

# CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

## Viral and Rickettsial Disease Laboratory

### **CONFIRMED NOROVIRUS OUTBREAK SUBMITTAL FORM FOR STRAIN TYPING\***

PLEASE SUBMIT BETWEEN 2 AND 5 POSITIVE ORIGINAL STOOLS WITH THE LOWEST CT VALUES AND THEIR CORRESPONDING RNA EXTRACTS PER OUTBREAK. (USE ADDITIONAL SUBMITTAL FORM IF NECESSARY)

Name of institution/City/County: \_\_\_\_\_  
 Type of institution/setting (e.g. long term care facility, school, camp, restaurant, hospital, jail, cruise ship, catered event, etc): \_\_\_\_\_  
 Number of residents/students/population-at-risk (if appropriate): \_\_\_\_\_  
 Number of staff (if appropriate): \_\_\_\_\_ Number Sick: \_\_\_\_\_  
 Date of first case: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last case: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Suspected source:    Food-borne    Water-borne    Person-to-person    Imported/travel    Unknown  
 If source identified, note any additional information available: \_\_\_\_\_  
 Total number of clinical cases: \_\_\_\_\_ Number of cases hospitalized: \_\_\_\_\_ Number of cases who died: \_\_\_\_\_  
 Total number of cases tested: \_\_\_\_\_ Total number of laboratory-confirmed cases: \_\_\_\_\_  
 Tested for bacteria?            Yes        No        Results: \_\_\_\_\_  
 Tested for ova and parasites?    Yes        No        Results: \_\_\_\_\_

\* Reminder: Outbreaks of any disease are reportable under the Title 17, California Code of Regulations. Please communicate with your local communicable disease control unit to ensure that any norovirus outbreaks are reported to the California Department of Health Services Statistics and Surveillance Section.

VRDL Patient Accession # (For VRDL Use Only)	Patient Name (Last Name, First Name)	Patient Info (circle and fill in)	Clinical Info	Sample Type	Local Results (circle)
	<b>Patient #1</b>	Sex: M or F	Date of Diarrhea	Stool	Type GI or GII
		DOB	Date Stool Collected	RNA Extract	Ct Value
	<b>Patient #2</b>	Sex: M or F	Date of Diarrhea	Stool	Type GI or GII
		DOB	Date Stool Collected	RNA Extract	Ct Value
	<b>Patient #3</b>	Sex: M or F	Date of Diarrhea	Stool	Type GI or GII
		DOB	Date Stool Collected	RNA Extract	Ct Value
	<b>Patient #4</b>	Sex: M or F	Date of Diarrhea	Stool	Type GI or GII
		DOB	Date Stool Collected	RNA Extract	Ct Value

LHD: \_\_\_\_\_ LHD Contact Name: \_\_\_\_\_  
 Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ Date form filled out: \_\_\_\_/\_\_\_\_/\_\_\_\_