

Gastroenteritis outbreak in a residential care facility Initial notification form

Do not leave any fields blank

Date of referral: Population Health Unit fax no.:		•				
Email address:	Date of referral:	Population Health Unit fax no.:				
Section 1: Facility details	Name and position of staff member reporting:					
Facility name:	Email address:					
Facility address:	Section 1: Facility details					
Suburb/town:	Facility name:					
Phone:	Facility address:					
Name of parent organisation: Does the facility have an Infection Control Advisor?	Suburb/town:			tcode:		
Does the facility have an Infection Control Advisor? Yes	Phone:	Fax:		pile:		
If yes, Name:	Name of parent organisation:					
Has the Infection Control Advisor been informed?	Does the facility have an Infection Control Advisor?	☐ Yes	□ No			
Section 2: Illness characteristics Total number of residents at facility: Number of ill residents: Total number of staff at facility: Number of ill staff: Date of onset of first case: Date of onset of last case: Symptoms: vomiting diarrhoea bloody diarrhoea fever abdominal pain Occupation of ill staff: nursing cleaning kitchen maintenance other - specify Staff with gastro excluded from facility until 48 hours after symptoms ceased? Yes No Section 3: Catering arrangements Food prepared on premises? Yes No Section 4: Living arrangements Residential settings: Single rooms: Yes No Shared rooms: Yes No Shared bathroom/toilet: Yes No Residential dining setting: Single, large communal dining area Small satellite dining areas Other, specify: Section 5: Specimen testing Specimens sent to laboratory: Yes No To be arranged If yes, name of laboratory: PathWest Other: Number of specimens sent:	If yes, Name:	IC Adv	isor's tel	ephone:		
Total number of residents at facility: Total number of staff at facility: Date of onset of first case: Symptoms:	Has the Infection Control Advisor been informed?	☐ Yes		□ No		
Total number of staff at facility: Date of onset of first case: Symptoms: vomiting diarrhoea bloody diarrhoea fever abdominal pain Occupation of ill staff: nursing cleaning kitchen maintenance other - specify Staff with gastro excluded from facility until 48 hours after symptoms ceased? Yes No Section 3: Catering arrangements Food prepared on premises? Yes - Name of catering manager: No - Name of food supplier: Section 4: Living arrangements Residential settings: Single rooms: Yes No Shared rooms: Yes No Shared bathroom/toilet: Yes No Residential dining setting: Single, large communal dining area Small satellite dining areas Other, specify: Section 5: Specimen testing Specimens sent to laboratory: Yes No To be arranged If yes, name of laboratory: PathWest Other: Number of specimens sent:	Section 2: Illness characteristics					
Date of onset of first case: Symptoms:	Total number of residents at facility:	Nun	nber of il	I residents:		
Symptoms:	Total number of staff at facility:	Nun	nber of il	l staff:		
Occupation of ill staff:	Date of onset of first case:	Date	e of onse	t of last case:		
Staff with gastro excluded from facility until 48 hours after symptoms ceased?	Symptoms: $\ \square$ vomiting $\ \square$ diarrhoea $\ \square$	bloody diarrh	oea 🗆	fever 🗆 abdominal pain		
Section 3: Catering arrangements Yes - Name of catering manager: No - Name of food supplier:	Occupation of ill staff: $\ \square$ nursing $\ \square$ cleaning $\ \square$	kitchen 🗆 m	naintenan	ce □ other – specify		
Food prepared on premises? Yes - Name of catering manager:	Staff with gastro excluded from facility until 48 hours after	symptoms cea	ased?	☐ Yes ☐ No		
Section 4: Living arrangements Residential settings: Single rooms: Shared rooms: Shared rooms: Shared bathroom/toilet: Yes No Shared bathroom/toilet: Yes No Single, large communal dining area Small satellite dining areas Other, specify: Section 5: Specimen testing Specimens sent to laboratory: If yes, name of laboratory: Number of specimens sent:	Section 3: Catering arrangements					
Residential settings: Single rooms: Yes No Shared rooms: Shared bathroom/toilet: Yes No Shared bathroom/toilet: Single, large communal dining area Small satellite dining areas Other, specify: Section 5: Specimen testing Specimens sent to laboratory: If yes, name of laboratory: Number of specimens sent:	Food prepared on premises? \square Yes $-$ Name	of catering ma	anager:			
Residential settings: Single rooms:	□ No – Name	of food suppli	ier:			
Shared rooms:	Section 4: Living arrangements					
Shared bathroom/toilet:	Residential settings:	ngle rooms:	e rooms:			
Residential dining setting: Single, large communal dining area Small satellite dining areas Other, specify: Section 5: Specimen testing Specimens sent to laboratory: If yes, name of laboratory: Number of specimens sent:	Sh	nared rooms:		□ Yes □ No		
Residential dining setting: Small satellite dining areas Other, specify: Section 5: Specimen testing Specimens sent to laboratory: If yes, name of laboratory: Number of specimens sent:	Sh	nared bathroom/toilet:				
Section 5: Specimen testing Specimens sent to laboratory:						
Section 5: Specimen testing Specimens sent to laboratory:						
Specimens sent to laboratory: If yes, name of laboratory: Description: Number of specimens sent:		Other, specify	у.			
If yes, name of laboratory:		□ Yes		No □ To be arranged		
Number of specimens sent:	·		•			
		☐ Yes	 □ Yes □ No			
	•			□ No		
Section 6: Hospitalisations and/or deaths						
	Any related hospitalisations:	☐ Yes [□ No	If yes, number:		
ATTY TOTALOG TIOOPILATIONION.	Any related deaths:		□ No	If yes, number:		
CONTRACTOR OF THE PROPERTY OF	·					
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