

Facility Name: \_\_\_\_\_

Facility Report Number \_\_\_\_\_

Class B Incident

**REPORTABLE EVENT: Initial Institutional Outbreak Data: INCIDENT/ ACCIDENT REPORT**

Date of Report: \_\_\_\_\_ Census: \_\_\_\_\_

Classification of illness: \_\_\_\_\_

Location of residents involved: \_\_\_\_\_

Total affected to date: Residents \_\_\_\_\_ Staff (if applicable) \_\_\_\_\_

Total currently symptomatic: Residents \_\_\_\_\_ Staff (if applicable) \_\_\_\_\_

Total critical residents: \_\_\_\_\_ Total hospitalized residents: \_\_\_\_\_

Total number of deaths: \_\_\_\_\_

Range of symptoms (including temperatures):  
\_\_\_\_\_  
\_\_\_\_\_

Treatment regime(s) initiated:  
\_\_\_\_\_  
\_\_\_\_\_

Laboratory/diagnostic result(s):  
\_\_\_\_\_  
\_\_\_\_\_

Containment measures initiated:  
\_\_\_\_\_  
\_\_\_\_\_

Inservices presented:  
\_\_\_\_\_  
\_\_\_\_\_

Notified of outbreak:

Medical director:

\_\_\_\_\_  
Name Date Time

Conn. Health Dept.

\_\_\_\_\_  
Person Contacted Date Time

Dept. Of Infectious Disease:

\_\_\_\_\_  
Person Contacted Date Time

Local Department of Health:

\_\_\_\_\_  
Person Contacted Date Time

Families: \_\_\_\_\_  
Date

Attending Physician(s): \_\_\_\_\_  
Date

Facility Contact Person: \_\_\_\_\_ / \_\_\_\_\_  
Print Name Signature

Director of Nurses: \_\_\_\_\_ Administrator: \_\_\_\_\_  
Signature Signature

Medical Director Signature: \_\_\_\_\_

