



FINAL REPORT DATE

**Maryland**  
DEPARTMENT OF HEALTH**Infectious Disease Epidemiology and Outbreak Response Bureau**  
**Division of Outbreak Investigation****Local Health Department Outbreak Summary Report: Respiratory Illness (non-COVID-19<sup>1</sup>)**

The local health department (LHD) is responsible for completing the report using data from the facility reporting the outbreak (OB). Instructions for fields marked with a superscript number (e.g., <sup>1</sup>) are provided at the end of the form. Sections I–V should be completed for **all** outbreaks.

Additionally:

- **Section VI** should be completed for outbreaks in healthcare facilities including hospitals, skilled nursing facilities, and assisted living facilities.
- **Section VII** should be completed for outbreaks in daycares.
- **Section VIII** should be completed for outbreaks in schools.

Facility Name	Facility Address			
County	MDH OB #	Date OB Closed		
Facility Type	<input type="checkbox"/> Assisted Living <input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Daycare <input type="checkbox"/> Group Home	<input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> K-12 School <input type="checkbox"/> Other:	Report Amended <sup>2</sup> ? <input type="checkbox"/> No <input type="checkbox"/> Yes # _____

Illness/Outbreak Type (check all that apply):

Influenza-like-illness (ILI)  Influenza (lab-confirmed)  Pneumonia  RSV (respiratory syncytial virus)  
 Group A Streptococcus (strep throat)  Pertussis  Other (please specify): \_\_\_\_\_

**I. INTRODUCTION**

Date Outbreak Reported	Reporter	Reporter's Phone Number	Main Contact	Main Contact's Phone Number
Facility to LHD <sup>3</sup>	Facility Reporter	Phone Number	Facility Contact <input type="checkbox"/> same as reporter	Phone Number
LHD to MDH <sup>4</sup>	LHD Reporter	Phone Number	LHD Contact <input type="checkbox"/> same as reporter	Phone Number
MDH Investigator	MDH Investigator's Phone Number			

**II. BACKGROUND**

	NON-EMPLOYEES	EMPLOYEES	TOTAL
Total number at the facility at the beginning of the outbreak			
If OB only affected one unit, department, or class, number at the beginning of the outbreak			
List affected units/floors/wings or classrooms/cohorts (if facility-wide, write "facility-wide") <sup>5</sup> :			

### III. CLINICAL RESULTS

For this section, counts are the numbers of <u>people</u> , not numbers of <u>tests</u> .	NON-EMPLOYEES	EMPLOYEES	TOTAL
Number of ill individuals			
Number of lab-confirmed individuals			
Number of individuals who visited a primary health care provider			
Number of individuals who visited an emergency department			
Number of individuals who were admitted to a hospital (for this illness)			
Number of individuals who died (from this illness)			
Earliest symptom onset date			
Latest symptom onset date			
Number of individuals with symptoms If symptom counts are unavailable, please list the predominant symptoms of this outbreak instead:			
Fever			
Cough			
Sore throat			
Shortness of breath			
Runny nose			
Nasal congestion			
Chest congestion			
Muscle aches			
Chills			
Rash			
Headache			
Vomiting			
Nausea			
Diarrhea			
Pneumonia			
Other (please specify): _____			
Number of individuals with a positive Chest X-ray (CXR) If yes, please describe findings – e.g., bilateral infiltrates, consolidation, interstitial changes:			
Duration of Symptoms for cases Shortest: _____	Longest: _____	Median: _____	

Did anyone receive a diagnosis from a medical professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, what was the diagnosis?
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#### IV. LABORATORY RESULTS

Was any laboratory testing done?

Yes  No (Skip to section V)  Unknown

Types of specimens obtained and tested (e.g., NP swab, sputum, etc.)		Type of tests performed (rapid, PCR, etc.)		Location where specimens were tested (e.g., LHD, MDHPHL, etc.)	
TEST	NON-EMPLOYEE # COLLECTED	NON-EMPLOYEE # POSITIVE	EMPLOYEE # COLLECTED	EMPLOYEE # POSITIVE	AGENT(S) IDENTIFIED
Influenza PCR					
Rapid influenza diagnostic test (RIDT or antigen test)					
SARS-CoV-2 (COVID-19) PCR					
SARS-CoV-2 (COVID-19) antigen					
RSV					
<i>Bordetella pertussis</i>					
Bacterial sputum culture					
<i>Legionella</i> urinary antigen					
<i>Streptococcus pneumoniae</i> urinary antigen					
<i>Legionella</i> culture					
<i>Legionella</i> PCR					
Other <sup>6</sup> : _____					

#### V. CONCLUSIONS

The etiology of the outbreak is: <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown	If confirmed or suspected, provide etiology:	Is the etiologic agent consistent with the observed course of the outbreak? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Etiology is suggested by the following epidemiological evidence collected in this investigation:

What is the suspected route of transmission of the infectious agent?

What is the suspected source of the outbreak?

Describe changes (if any) in infection control practices at the conclusion of the OB:

Additional comments:

**VI. HOSPITAL AND LONG-TERM CARE FACILITIES (Complete for hospital/LTC outbreaks only)**

Name of infection preventionist (IP) or other individual responsible for infection control:	Phone Number	Has IP taken the training course? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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How was the outbreak initially recognized by staff (check all that apply)?

<input type="checkbox"/> An unusually high number of cases among staff overall	<input type="checkbox"/> An unusually high number of facility-acquired cases among patients/residents in a common unit
<input type="checkbox"/> An unusually high number of cases among staff in a common unit	<input type="checkbox"/> Increased surveillance of employee callouts
<input type="checkbox"/> An unusually high number of facility-acquired cases among patients/residents overall	<input type="checkbox"/> Met the MDH outbreak definition
	<input type="checkbox"/> Other: _____

Which unit/department/individual compiles information about employee illness/call outs?	Are employees who call out ill asked about their symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Does the facility keep baseline statistics on employee call outs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, do they track (check all that apply): <input type="checkbox"/> Daily percentages <input type="checkbox"/> Monthly percentages <input type="checkbox"/> Weekly percentages <input type="checkbox"/> Unknown
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Influenza vaccination coverage rate (fraction or percentage) Among residents/patients: Among staff:	Pneumococcal vaccination rate (fraction or percentage) among residents/patients:
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Were admissions to the OB unit(s) and/or facility restricted?

Yes  No

If restricted, provide the unit(s) and dates admissions were restricted. If it is facility-wide, check facility-wide and provide dates.

Unit: \_\_\_\_\_ Dates restricted: \_\_\_\_\_  
 Unit: \_\_\_\_\_ Dates restricted: \_\_\_\_\_  
 Unit: \_\_\_\_\_ Dates restricted: \_\_\_\_\_  
  
 Facility-wide Dates restricted: \_\_\_\_\_

What control measures were implemented (check all that apply)?

<input type="checkbox"/> Provided or reviewed outbreak control checklist	<input type="checkbox"/> Limited or suspended group activities
<input type="checkbox"/> Restricted admissions	<input type="checkbox"/> Isolated ill resident/patients
<input type="checkbox"/> Restricted resident movement (e.g., remain in room)	<input type="checkbox"/> Restricted personnel movement (i.e., cohorted staff)
<input type="checkbox"/> Cohorting of ill/exposed residents/patients	<input type="checkbox"/> Increased environmental cleanliness
<input type="checkbox"/> Notified visitors (e.g., posted signs)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Vaccinations recommended	

**FOR INFLUENZA OUTBREAKS ONLY**

Were antivirals (e.g., oseltamivir) given as part of this outbreak? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Which category of individuals received antiviral(s)? <input type="checkbox"/> Residents/patients with lab-confirmed influenza <input type="checkbox"/> Residents/patients with ILI or other respiratory illness <input type="checkbox"/> Ill staff <input type="checkbox"/> Other: _____	Which category of individuals received antiviral chemoprophylaxis? <input type="checkbox"/> All well residents/patients: <input type="checkbox"/> On outbreak unit(s) only <input type="checkbox"/> Facility-wide <input type="checkbox"/> All well staff: <input type="checkbox"/> On outbreak unit(s) only <input type="checkbox"/> Facility-wide <input type="checkbox"/> Other: _____
If yes, antiviral(s) given: _____ _____		

**VII. DAYCARE (Complete for daycare outbreaks only)**

Type of daycare <input type="checkbox"/> Home <input type="checkbox"/> Center	If home daycare, name of home:
Specify the age range of ill daycare attendees: From _____ to _____	Absenteeism Day of report (number or percentage): Baseline (number or percentage):
Did the daycare facility close due to the OB? <input type="checkbox"/> Yes <input type="checkbox"/> No	If closed, provide the dates of the closure:

**VIII. SCHOOL (Complete for K-12 school outbreaks only)**

Type of school <input type="checkbox"/> Public <input type="checkbox"/> Private	School description <input type="checkbox"/> Elementary <input type="checkbox"/> Middle school <input type="checkbox"/> High school <input type="checkbox"/> K-8 <input type="checkbox"/> K-12
Absenteeism Day of report (number or percentage):	Baseline (Number or percentage):
Did the school close because of the outbreak? <input type="checkbox"/> Yes <input type="checkbox"/> No	If closed, provide the dates of closure:

**FURTHER INSTRUCTIONS**

<sup>1</sup> For COVID-19 outbreaks, please complete the COVID-19 [Outbreak Summary Report Form](#). For reporting other communicable disease outbreaks, refer to the [MDH Disease/Condition-Specific Forms](#) webpage.

<sup>2</sup>If a report has been submitted for this outbreak before, check Yes. Indicate how many times the report has been submitted (for example, if you have submitted it once before and then had to revise and resubmit, you would indicate that this is #2).

<sup>3</sup>Date that the facility first reported the outbreak to the LHD.

<sup>4</sup>Date that LHD first reported the outbreak to MDH. If the outbreak reopens, use the original reporting date.

<sup>5</sup>For example, 2<sup>nd</sup> floor, X unit, Y classroom, 5<sup>th</sup> grade teachers, kindergarten teachers, soccer team.

<sup>6</sup>Other tests may include respiratory panels such as BioFire or bacterial or viral cultures.

**ATTACHED MATERIALS:**

- Line list
- Epi-curve
- Other: \_\_\_\_\_

LHD Signature: \_\_\_\_\_ Date sent by LHD: \_\_\_\_\_