Gastrointestinal Outbreak Tracking - Staff



• Complete and email form to applicable zone:

Edmonton Zone - edm.eph.gioutbreak@ahs.ca

Calgary Zone - gioutbreaks.calzone@ahs.ca

North Zone - ahs.nz.eph.diseasecontrolteam@ahs.ca South Zone - sz.cdceph.triage@ahs.ca Central Zone - ahs.cz.eph.diseasecontrolteam@ahs.ca

| Facility | | | | | | | | |
|---|--------------------------|--------------------------|----------------------|------|--------------------------|---------|--|--|
| Total Number of Staff on Affected Unit | | Outb | Outbreak (EI) Number | | | | | |
| Facility Name | | | Unit/Floor Affecte | ed | | | | |
| Address | | | | P | Postal Cod | e | | |
| Contact/Designate Name | | | Phone | | Fax | | | |
| ONLY ADD NEWLY SYMPTOMATIC STAFF | | | | | | | | |
| Staff Last Name (Legal) | Staff First Name (Legal) | | | (| Onset Date (dd-Mon-yyyy) | | | |
| DOB (dd-Mon-yyyy) | Phone Number | | | | | | | |
| Symptoms within onset day (midnight to 2359 hours) of initial number of episodes of vomiting and/or diarrhea. | | | | | | | | |
| □ Vomiting, number of episodes? □ Diarrhea, number of episodes? | | | | | | | | |
| Other Symptoms | | | | | | | | |
| Test Performed/Lab Results | | | Stool Sample T | aken | □ Yes | □ No | | |
| Result | | | | | | | | |
| Returned to Work Date (dd-Mon-yyyy) | | | | | | | | |
| Comments | | | | | | | | |
| Comments | | | | | | | | |
| | | | | | | | | |
| Staff Last Name (Legal) | Stoff First Nar | | | | Onact Dat | - ///// | | |
| Stait Last Name (Legal) | Stall Filst man | Staff First Name (Legal) | | | Onset Date (dd-Mon-yyyy) | | | |
| DOB (dd-Mon-yyyy) | | Pho | ne Number | I | | | | |
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| □ Vomiting, number of episodes? □ Diarrhea, number of episodes? | | | | | | | | |
| □ Other Symptoms | | | | | | | | |
| Test Performed/Lab Results | | | Stool Sample T | aken | □ Yes | D No | | |
| Result | | | | | | | | |
| Returned to Work Date (dd-Mon-yyyy) | | | | | | | | |
| Comments | | | | | | | | |
| | | | | | | | | |



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|--|--------------------------|-------------------------------|---|--|--|--|--|
| DOB (dd-Mon-yyyy) | | Phone Number | | | | | |
| Symptoms within onset day (<i>midnight to 2359 hours</i>) of initial number of episodes of vomiting and/or diarrhea. | | | | | | | |
| Vomiting, number of episodes? | | Diarrhea, n | umber of episodes? | | | | |
| D Other Symptoms | | | | | | | |
| Test Performed/Lab Results | | Stool Sample Taken | □ Yes □ No | | | | |
| Result | | | | | | | |
| Returned to Work Date (dd-Mon-yyyy) | | | | | | | |
| Comments | | | | | | | |
| | | | | | | | |
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| Other Symptoms | | | | | | | |
| Test Performed/Lab Results Result | | Stool Sample Taken | □ Yes □ No | | | | |
| Returned to Work Date (dd-Mon-yyyy) | | | | | | | |
| Comments | | | | | | | |
| Commenta | | | | | | | |
| | | | | | | | |
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| Other Symptoms | | | | | | | |
| Test Performed/Lab Results | | Stool Sample Taken | □ Yes □ No | | | | |
| Result | | | | | | | |
| Returned to Work Date (dd-Mon-yyyy) | | | | | | | |
| Comments | | | | | | | |
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