



| |
|-----------------------------|
| VDH Use Only: |
| VDH/NORS Outbreak #: _____ |
| Mode of transmission: _____ |
| _____ |

*Norovirus-like illness is defined as acute onset of vomiting and non-bloody diarrhea

Reporting Information

Date of report: ____ / ____ / ____ Person taking the report: _____

Name of facility: _____ Type of facility: _____

Facility address: _____ County: _____

Caller Information

Name of caller: _____

E-mail address: _____ Phone: (____) _____ - _____

Clinical Information

Date first case became ill: ____ / ____ / ____ Date last case became ill: ____ / ____ / ____

Shortest duration of illness: _____ Longest duration of illness: _____ Average duration of illness: _____

Number of ill in first group: ____ First group description*: _____ Total in first group: ____

Number of ill in second group: ____ Second group description*: _____ Total in second group: ____

*Group description could be: staff, residents, different wards, floors, grades, etc. Total ill among all groups: ____

Laboratory Information

Was laboratory testing performed?: Yes No

If yes, where?: _____

Were specimens sent to the Department of Health Laboratory? Yes No

If yes, what were the results?: _____

How many lab-confirmed primary cases?: _____

Case Demographics

| | | | | | |
|--|-------------------------------------|---------------------|-------------------------------------|---------------------|--------------|
| Of the total cases, number of or with: | # of Male ____ | # of Female ____ | # of Unknown ____ | | |
| | # of <1 yr ____ | # of 1-4 yrs ____ | # of 5-9 yrs ____ | # of 10-19 yrs ____ | |
| | # of 20-49 yrs ____ | # of 50-74 yrs ____ | # of 75+ yrs ____ | | |
| | # Died ____ | # Hospitalized ____ | | | |
| | # Visited Emergency Department ____ | | # Visited Health Care Provider ____ | | |
| | # Vomiting ____ | # Diarrhea ____ | # Bloody stool ____ | # Nausea ____ | # Fever ____ |
| # Abdominal cramps ____ | # Chills ____ | # Myalgia ____ | # Other symptoms _____ | | |

Notes:

Please email completed form back to original sender or fax to (802) 951-4061