

CONFIDENTIAL

v1.0 January 2014

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CORE outbreak details: please complete page 1&2
Follow up outbreak details: please complete relevant sections on page 3-5

CORE OUTBREAK INFORMATION

Date of Notification to Public Health Department:

Outbreak ID

Disease/ organism

Outbreak status: Open Closed HSE Area CCA County

Date outbreak 1st reported (to public health) Date outbreak recognised

Date of onset of 1st case Date of onset of last case

Outbreak reported by Reporter position

Reporter telephone Reporter fax

Reporter email

Outbreak notified by: EHO Infection control nurse Hospital clinician Food outlet proprietor
GP Nurse manager Laboratory report Public complaint
Other

If other outbreak notification source please specify:

Outbreak extent: Local Across HSE area National Cross border International

Outbreak type: Family General

Outbreak location:

Private house <input type="checkbox"/>	Community outbreak <input type="checkbox"/>	Public house/ bar <input type="checkbox"/>	Childcare facility <input type="checkbox"/>
Extended family <input type="checkbox"/>	Community hospital/ long stay unit <input type="checkbox"/>	Restaurant/ cafe <input type="checkbox"/>	School <input type="checkbox"/>
Guesthouse/ B&B <input type="checkbox"/>	Residential institution <input type="checkbox"/>	Workplace <input type="checkbox"/>	University/ college <input type="checkbox"/>
Hotel <input type="checkbox"/>	Nursing home <input type="checkbox"/>	Staff canteen <input type="checkbox"/>	Pet farm/ petting zoo <input type="checkbox"/>
Travel related <input type="checkbox"/>	Hospital <input type="checkbox"/>	Mobile retailer <input type="checkbox"/>	Retail outlet <input type="checkbox"/>
Coach tour <input type="checkbox"/>	Other <input type="checkbox"/>	Unknown <input type="checkbox"/>	

If other outbreak location, please specify:

Outbreak mode of transmission: (please tick ALL that apply)

Water-borne Person to person Animal contact Airborne Other
Food-borne Environmental/ fomite Vector-borne Unknown

If other mode of transmission, please specify:

Comments:

HSE area comments:

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Laboratory details

Was there a pathogen identified? Yes No Unk
Suspect viral aetiology? Yes No Unk

Organism/pathogen
Specify any secondary pathogens/ co-infections identified

Serotype Toxin type
Phage type Antibiogram
RT- PCR result: Pos Neg Unk Genogroup/ genotype
EM Result Pos Neg Unk Sequence Information

Number specimens tested - symptomatic total	<input type="text"/>	Number specimens positive - symptomatic total	<input type="text"/>
Number specimens tested - asymptomatic total	<input type="text"/>	Number specimens positive - asymptomatic total	<input type="text"/>
Number specimens tested - symptomatic foodhandlers	<input type="text"/>	Number specimens positive - symptomatic foodhandlers	<input type="text"/>
Number specimens tested - asymptomatic foodhandlers	<input type="text"/>	Number specimens positive - asymptomatic foodhandlers	<input type="text"/>

Summary exposure data

Total number ill	<input type="text"/>	Number by age group:
Total number hospitalised	<input type="text"/>	0-1 years <input type="text"/>
Total number dead	<input type="text"/>	2-4 years <input type="text"/>
Number dead due to this ID	<input type="text"/>	5-9 years <input type="text"/>
Number dead not due to this ID	<input type="text"/>	10-19 years <input type="text"/>
Total number at risk / exposed	<input type="text"/>	20-49 years <input type="text"/>
Total number lab investigated	<input type="text"/>	50-64 years <input type="text"/>
Number lab confirmed	<input type="text"/>	65+ years <input type="text"/>
Number with clinical symptoms only	<input type="text"/>	Age unknown <input type="text"/>
Number primary cases	<input type="text"/>	
Number secondary cases	<input type="text"/>	
Total by sex, Males	<input type="text"/>	
Total by sex, Females	<input type="text"/>	
Total by sex, Unknown	<input type="text"/>	

Symptoms

Symptoms (continued):

Nausea <input type="checkbox"/>	Fever <input type="checkbox"/>	Sore throat <input type="checkbox"/>	Cough <input type="checkbox"/>	Rash <input type="checkbox"/>
Vomiting <input type="checkbox"/>	Headache <input type="checkbox"/>	Runny nose <input type="checkbox"/>	Haemoptysis <input type="checkbox"/>	Purpura <input type="checkbox"/>
Abdominal pain <input type="checkbox"/>	Malaise <input type="checkbox"/>	Sneezing <input type="checkbox"/>	Shortness of breath <input type="checkbox"/>	Lumps/ swelling <input type="checkbox"/>
Diarrhoea <input type="checkbox"/>	Myalgia <input type="checkbox"/>	Conjunctivitis <input type="checkbox"/>	Dyspnoea <input type="checkbox"/>	Paralysis <input type="checkbox"/>
Bloody diarrhoea <input type="checkbox"/>	Jaundice <input type="checkbox"/>	Visual problems <input type="checkbox"/>	Collapse <input type="checkbox"/>	Other <input type="checkbox"/>
Other please specify <input type="text"/>				

Travel association

Was this outbreak foreign travel associated? Yes No Unk
If yes, which country?



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Transmission via food

Date of suspect function / event

Food vehicle¹:
Food vehicle details:

Place of origin of problem (where exposure took place)²
Country of origin of implicated food

Food contributory factors:	Yes	No	Unk		Yes	No	Unk
Unprocessed contaminated ingredient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foodhandler(s) symptomatic before outbreak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate heat treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foodhandler(s) symptomatic during outbreak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate chilling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infected foodhandler(s) asymptomatic carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inadequately trained staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Storage time/temp. abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cross contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inadequate hygiene facilities/ conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contaminated raw ingredient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other contributory food-borne factor(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contaminated pre-cooked ingredient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Food control measures:

Transmission via water

Drinking water supply:

Public water supply	<input type="checkbox"/>	Private household domestic well (Exempt)	<input type="checkbox"/>
Public group water scheme (Regulated)	<input type="checkbox"/>	Small private water scheme (Exempt)	<input type="checkbox"/>
Private group water scheme (Regulated)	<input type="checkbox"/>	Bottled water	<input type="checkbox"/>
Private scheme owned by individual (Regulated)	<input type="checkbox"/>	Other	<input type="checkbox"/>
Private well serving commercial premises (Regulated)	<input type="checkbox"/>	Unknown	<input type="checkbox"/>

If other drinking water supply please specify:

Drinking water source:

Ground Surface (inc. lakes rivers) Spring (inc. wells and boreholes) Mixture Unknown

Supply treatment:	Yes	No	Unk		Yes	No	Unk		Yes	No	Unk
Chlorination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pressure filtration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow sand filtration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coagulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid gravity filtration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	UV disinfection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ozonisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sedimentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								Other treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If other supply treatment, please specify:

Water contributory factors:

	Yes	No	Unk		Yes	No	Unk
No/inadequate treatment for outbreak pathogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water treatment failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substandard borehole construction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distribution system failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other contributory water-borne factor(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contaminated raw water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If other WB contributory factor please specify
Source of contamination
Drinking water control measures

¹: See Appendix 1 page 6 for CIDR food vehicle drop down list

²: See Appendix 2 page 6 for CIDR place of origin of problem drop down list

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Transmission via recreational water

Recreational water type:

Freshwater swimming pool Open fresh water Paddling pool Spa
 Seawater swimming pool Open sea water Other recreational water

If other recreational water type please specify:

Primary client type: Primarily adult pool Toddler/learner pool Other usage

Primary client type other, please specify:

Recreation water contributory factors:

	Yes	No	Unk
No/ inadequate disinfection/ treatment of water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of substandard water management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outbreak preceded by a recognised faecal incident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No systematic recording of faecal incidents at pool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If open water outbreak, preceded by high rainfall/flooding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If other recreational water contributory factor, please specify:

Recreational water control measures taken

Transmission via animal contact

Group affected: School group Trainees/3rd level students General public Other
 If other group affected, please specify

Animal species suspected as source

Type of contact with animals suspected as source

Animal contact contributory factors:

	Yes	No	Unk
Evidence of illness/scouring in animal(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No signage/instruction available to visitors re hand hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate hand washing facilities or alcohol gels provided?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate adult supervision of groups regarding contact & hygiene?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Animal contact control measures taken

Transmission in health care settings

Total number of staff	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number of clients/patients	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number staff symptomatic	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number clients/patients symptomatic	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number of staff vaccinated prior to outbreak	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number of clients/patients vaccinated prior to outbreak	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number of symptomatic staff vaccinated prior to outbreak	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number of symptomatic clients/patients vaccinated prior to outbreak	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number staff recommended anti-viral treatment	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number clients/patients recommended anti-viral treatment	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number staff recommended prophylaxis	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number clients/patients recommended prophylaxis	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Influenza outbreaks

Name of laboratory where tests were conducted

Were specimens referred to NVRL? Yes No Unk Date referred to NVRL

Which pathogens were tested for? Standard ILI suite ILI suite & influenza A(H1N1) Unknown

Total number of cases with pneumonia Total number of cases with encephalitis

Total number of cases with otitis Total number of cases with other complications

If other complications, please specify

Control measures for influenza outbreaks

	Yes	No	Unk		Yes	No	Unk
Hygiene advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quarantine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information/self-monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closure of institution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antivirals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Advice on respiratory etiquette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contacts vaccinated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Isolation/Cohorting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tuberculosis outbreaks

Number active cases	<input type="text"/>	Number contacts with chest x-ray completed	<input type="text"/>
Number latent cases	<input type="text"/>	Number contacts commenced on chemoprophylaxis	<input type="text"/>
Number contacts identified	<input type="text"/>	Number contacts completed chemoprophylaxis	<input type="text"/>
Number contacts screened	<input type="text"/>	Number contacts completed 1st round of screening	<input type="text"/>
Number contacts requiring chest x-ray follow up	<input type="text"/>	Number contacts completed 2nd round of screening	<input type="text"/>

Outbreak evidence

Overall outbreak evidence strength: Strong evidence Weak evidence **Percentage of cases exposed**

Summary of descriptive epidemiological evidence:

Strong descriptive epi evidence Weak descriptive epi evidence No descriptive epi evidence

Was an analytical study undertaken? Yes No Unk

Type of analytical study: Case control Cohort

Analytical study - statistically significant result? Yes No Unk

If significant, specify variables associated with illness, strength of association, confidence limits & p values

Summary of analytical evidence obtained

Strong analytical evidence Weak analytical evidence No analytical evidence

Microbiological evidence supporting a link between the suspected vehicle and the cases? Yes No Unk

Outbreak pathogen detected in sample of the suspected vehicle?

Yes - indistinguishable causative agent cases & vehicle No micro evidence - suspected source

Yes - causative agent in cases & vehicle Unk micro evidence - suspected source

Outbreak pathogen detected in sample of the environment of suspected vehicle?

Yes - indistinguishable causative agent cases & vehicle environment No micro evidence - environment

Yes - causative agent case & vehicle environment Unk micro evidence - environment

Outbreak pathogen detected in sample from supply chain of suspected vehicle?

Yes - indistinguishable causative agent cases & supply chain No micro evidence - supply chain

Yes - causative agent cases & supply chain Unk micro evidence - supply chain

Any further details on microbiological findings

Was similar pathogen/indicator organism detected in sample of suspected vehicle? Yes No Unk

Summary of microbiological evidence supporting link between illness and any exposure:

Strong microbiological evidence Weak microbiological evidence No microbiological evidence

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[Follow up outbreak details: please complete relevant sections on \[page 3-5\]\(#\)](#)

Appendices

Appendix 1: Food vehicle

- Cereal products including rice/seeds/pulses/nuts
- Fruit, berries and juices & assoc products
- Vegetables and juices & assoc products
- Dairy products (other than cheeses)
- Eggs and egg products
- Cheese
- Milk
- Tap water, including well water
- Drinks, including bottled water
- Bovine meat & assoc products
- Broiler meat (Gallus gallus) & assoc products
- Pig meat & assoc products
- Sheep meat & assoc products
- Turkey meat & assoc products
- Fish and fish products
- Crustaceans, shellfish, molluscs & assoc products
- Other or mixed red meat & assoc products
- Other, mixed or unspec poultry meat & products
- Canned food products
- Sweets and chocolate
- Bakery products
- Buffet meals
- Other foods
- Mixed food
- Herbs and spices

Appendix 2: Place of origin of the problem:

-
- Restaurant, Cafe, Pub, Bar, Hotel,
- Catering
- Temporary mass catering (fairs, festivals)
- Mobile retailer,
- market/street vendor
- Restaurant, Cafe, Pub, Bar, Hotel
- Canteen or workplace catering
- Take-away or fast-food outlet
- Household / domestic kitchen
- Water distribution system
- at hospital or care home
- Aircraft, ship, train
- Water treatment plant
- School, kindergarten
- at packing centre
- at slaughterhouse
- Transport of food
- Travel abroad
- Camp, picnic
- Water source
- at retail
- at farm
- Unknown
- Other