Appendix A – Patient Line Listing for Influenza-Like Illness

DATE: ____________ SITE/FACILITY/UNIT/ ______________________ PHONE # _____

If no addressograph, please include: Full Name HSN DOB Physician		***Addressograph***	***Addressograph***	***Addressograph***
	Room #			
	Onset Date			
	Onset Time			
	Isolation (Y/N)			
SYMPTOMS	Fever			
	Cough			
	Muscle Aches			
	Joint Pain			
	Sore Throat			
	Temp (°C)			
	Fatigue/Malaise			
	Other (Specify)			
SPECIMENS	Date Collected			
	DFA Result			
	Culture Results			
Duration of Illness				
Update and Comments				