

## Staff Linelisting Respiratory Illness

Date Started: \_\_\_\_\_

LTC Home: \_\_\_\_\_

Full Name	D.O.B D/M/Y	Gender	* Job Description	**Floor/Unit	Onset Date	Influenza Immunization Y or N	Date Immunized	***Symptoms (see below)	Date Specimen Collected	Results (enter in DFA)	Date Last Worked	Date Returned to Work	Duration of Illness	Comments (e.g. works in another location)
Case Override <input type="checkbox"/>														
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<p><b>*** Symptoms &amp; Frequency</b></p> <p>T = Temp (specify)      F = Extreme Fatigue          C = Cough (describe)      J = Joint Pain          H = Headache      S = Sore Throat          R = Runny Nose      M = Muscle Aches          Anything else, specify exact symptom</p>	<p><b>*Job Description:</b></p> <ul style="list-style-type: none"> <li>• Dietary</li> <li>• R.N.</li> <li>• S.C.A.</li> <li>• Housekeeping</li> <li>• Activities</li> <li>• Laundry</li> <li>• Maintenance</li> <li>• PT/OT</li> <li>• Office</li> <li>• Other - specify</li> </ul>	<p><b>**Floor/Unit:</b> e.g. 1<sup>st</sup>, North, All</p>
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