Government of **Western Australia**
Department of **Health**
Communicable Disease Control Directorate

Gastroenteritis Outbreak in a Residential Care Facility

Initial Notification Form

Date of referral:	Population Health Unit Fax No.
Name and position of staff member reporting:	
Do not leave any fields blank	

SECTION 1: REFERRAL SOURCE OR OUTBREAK COORDINATOR

Facility Name:		
Facility address:		
Suburb/town:		Postcode:
Phone:	Fax:	Mobile:
Name of parent organisation:		
Does the facility have an Infection Control Advisor?	☐ Yes	☐ No
If yes, Name:	IC Advisor's telephone:	
Has the Infection Control Advisor been informed?	☐ Yes	☐ No

SECTION 2: ILLNESS CHARACTERISTICS

Total number of residents at facility:	Number of ill residents:
Total number of staff at facility:	Number of ill staff:
Date of onset of first case:	Date of onset of last case:

Symptoms: ☐ vomiting ☐ diarrhoea ☐ bloody diarrhoea ☐ fever ☐ abdominal pain

Occupation of ill staff: ☐ nursing ☐ cleaning ☐ kitchen ☐ maintenance ☐ other - specify

Staff with gastro excluded from facility until 48 hours after symptoms ceased? ☐ Yes ☐ No

SECTION 3: CATERING ARRANGEMENTS

Food prepared on premises?	☐ Yes Name of catering manager:
	☐ No Name of food supplier:

SECTION 4: LIVING ARRANGEMENTS

Residential settings:	Single rooms:	☐ Yes	☐ No
	Shared rooms:	☐ Yes	☐ No
	Shared bathroom/toilet:	☐ Yes	☐ No
Residential dining setting:	☐ Single, large communal dining area ☐ Other, specify:	☐ Small satellite dining areas	

SECTION 5: SPECIMEN TESTING

Specimens sent to laboratory:	☐ Yes	☐ No	☐ To be arranged
If yes, name of laboratory:	☐ PathWest	☐ Other:	
Number of specimens sent:			
Norovirus, rotavirus, adenovirus requested:	☐ Yes	☐ No	
Microscopy, culture & sensitivities (M,C&S) requested	☐ Yes	☐ No	

SECTION 6: HOSPITALISATIONS AND/OR DEATHS

Any related hospitalisations:	☐ Yes	☐ No	If yes, number:
Any related deaths:	☐ Yes	☐ No	If yes, number: