Resident Outbreak Line List for COVID-19

Facility Name: _____ **County:**_____

Contact Person Name _____ **Contact Phone #**_____

Demographics				Duration of Illness				Symptoms			Laboratory		Outcome		
Name	DOB	Sex	Room #	Date of Onset	Date Placed in Isolation	Date Isolation Discontinued	Date Well	Highest Temp	Cough (Y/N)	Shortness of Breath (Y/N)	Date of Lab Testing	Testing Result	Hospitalized (Y/N)	Died (Y/N)	Contact Tracing Completed (Y/N)

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