

INSTRUCTIONS FOR COMPLETING INFLUENZA REPORTING FORM

#1. Reporting type:

- INITIAL should be checked for:
 - The first report of ILI in a facility/program
 - Any other outbreak of ILI at a facility that occurs more than 7 days from the date of the last onset of symptoms. (e.g.: Person #1 symptoms on 11/12, Person #2 symptoms 11/13. Person #3 onset of symptoms 11/24 – Person #3 is an initial report as it is greater than 7 days from the date of the last person with ILI becoming ill.)

- UPDATE should be checked for
 - Updating the status of a person previously reported with ILI (e.g. hospitalized)
 - Additional individuals who become ill within 7 days of the last onset of symptoms. (e.g.: Person #1 symptoms 11/12; person #2 onset of symptoms 11/13 Person #2 is reported as an update of the original report)
 - When correcting “unknown” or inaccurate information on initial report
 - When updating be sure to include the reference number from the initial report.

#2 Date of Report: the date you submit the report

#3. Date of onset of symptoms: the date that the first individual was reported with symptoms. For update, backdate to the “date of onset of symptoms” on original report.

#4. Assigned DDSO is the DDSO for the geographic area where the facility is located.

#5. Agency name. For state operated facilities, enter “DDSO.”

#6. Facility name: the name of the program/site

#7, 8, 9, 10, 11. Facility address: the street address, city, state, zip code and county of the actual program site (NOT the main office or corporate headquarters for the agency).

#12, 13. Contact is the person that the DDSO can contact for further information if needed. Generally this will be the nurse assigned the site, but may be other staff (such as the administrator for the site).

#14: Facility type. If not a residential or day program, enter “Other”

#15. Number of individuals at the site: this is the number of individuals with developmental disabilities who are routinely at the site

#16. Number of staff assigned to the site: This is the number of staff, not number of FTEs. Part time staff would be counted as “1”

#17. Number of individuals with ILI: this is the number of persons with developmental disabilities at the site who have ILI at the time of the report.

- #17a. Of the individuals with developmental disabilities with ILI, the number who had ONLY the H1N1 vaccine.
- #17b. Of the individuals with developmental disabilities with ILI, the number who had ONLY the seasonal flu vaccine.
- #17c. Of the individuals with developmental disabilities with ILI, the number who had BOTH the seasonal flu and the H1N1 vaccine.
- **NB:** the total of 17 a, 17 b and 17 c cannot be more than the number of individuals with ILI indicated in #17**
- #18. Of the individuals with ILI, number with Influenza confirmed by testing: This would include influenza that was confirmed by any test. If there is test-confirmed ILI, enter the type(s) of tests used in the “comments” section in question #26.
- #19. Number of staff with influenza-like illness. This is the number of staff assigned to this site that has ILI. If staff from other programs have ILI, that would be a separate report.
- #20. Number of persons hospitalized. Please include here only persons with developmental disabilities who are hospitalized. If a staff person is hospitalized, please indicate that in the “comments” section question #26.
- #21. Number of deaths. . Please include here only persons with developmental disabilities who die as a result of ILI and or suspected or confirmed cases of influenza. If a staff person dies as a result of ILI and or suspected or confirmed cases of influenza please enter that information in “comments” section in question #26.
- #22. Individuals on prophylaxis? Please indicate if the persons with developmental disabilities at the site have been placed on prophylactic medication. If only some consumers are placed on prophylaxis, please explain in the “comments” section in question #26.
- #23. Staff on prophylaxis? Please indicate if the staff at the site have been placed on prophylactic medication.
- #24. Other programs impacted. Please list here all other programs that have had individuals/staff exposed to the person with ILI from 24 hours before symptoms appeared to the present.
- For residential programs this would include the day programs, the transportation company, the day program, any other group activity, MS Coordinators, therapists and others who may have been within 6 feet of the individual.
 - For day programs, this would include all of the residential programs that have individuals attending the day program, the transportation company, families of individuals who live at home, and others who would have been within 6 feet of the individual.
- #25. Control measures taken by the facility. Check all that apply.

#26. Comments. In addition to those items indicated above, please type in any additional information related to this outbreak that you feel would be of importance for the infection control staff at the DDSO to know.

All reports are reviewed on a regular basis. DDSOs and/or OMRDD Central Office will follow up with agencies as needed. DDSO staff remain available to assist agencies in their efforts to manage outbreaks of influenza. Please feel free to contact the DDSO or Health Services at COF.Health@omr.state.ny.us if you have questions or concerns, either about this form, or about the management of influenza in OMRDD certified facilities.