Line Listing for Long Term Care Residents: Viral Respiratory Infection 2026-2027

Public Health

Facility Name:_____ Facility Contact Person:_____ Phone Number:_____ Outbreak #:_____

Date Case Reported to Public Health Enter date below: YY-MM-DD	**Room Number**	**Unit Name**	**Resident Name**	**Date of Birth** Enter date below: YY-MM-DD	**Health Card Number**	**Date Specimen Collected** Enter date below: YY-MM-DD	**PCR test**	**POCT test**	**Symptomatic not tested**	**Date of Symptom Onset** Enter date below: YY-MM-DD	**Cough**	**Fever (temp ≥ 37.8°C) chills or sweats**	**Shortness of breath/difficulty breathing**	**Loss or change in sense of smell or taste**	**Sore throat, runny nose/nasal congestion/ excessive sneezing**	**Headache**	**Muscle Aches**	**Change baseline, including confusion/ delirium (specify under comments)**	**Unexplained symptoms***	**Influenza lab-confirmed**	**COVID-19 lab-confirmed**	**RSV lab-confirmed**	**Hospitalization**	**Death**	**Comments**

NOTE: Mark an X for all symptoms that apply. Add new residents and send to Public Health daily by secure data transfer method. Line list can be printed or completed electronically.*Unexplained symptoms including, but not limited to nausea/vomiting/diarrhea, and/or extreme fatigue.