Influenza, Influenza-like Illness, Upper Respiratory Illness
LINE LIST FORM

Facility Name _____

Case initials	Pt. Room		Symptom onset date	Fever Y/N	T max °	Cough Y/N	Sore throat Y/N	Headache Y/N	Myalgia Y/N	Hospitalized		Died Y/N	Flu Vax Y/N	Lab Testing				
	#	Unit								Y/N	Admit Date			Y/N	Collect Date	Type of test	Result	Antiviral Rx or PEP

*ND = not done