BC Centre for Disease Control
An agency of the Provincial Health Services Authority

British Columbia Influenza Surveillance Bulletin

Influenza Season 2015-16, Number 17, Weeks 12-13
March 20 to April 2, 2016

Table of Contents:

Past Epidemic Peak but Late-season Influenza Activity Remains Elevated in BC

In weeks 12-13 (March 20 to April 2, 2016), most influenza surveillance indicators continued to decline, and the epidemic peak in BC has passed. However, with a late start to the season, influenza activity remains higher than expected for this time of year.

At the BCCDC Public Health Laboratory, influenza positivity was around 30% in weeks 12-13, declining from a peak of 45% in week 6 but still higher than inter-seasonal levels. A(H1N1)pdm09 viruses continued to predominate, comprising >60% of influenza detections with known type/subtype, and with co-circulation of influenza B viruses.

Influenza outbreaks in facilities also continue to be reported. Since our last bulletin two weeks ago, five new influenza outbreaks were reported with onset in weeks 12-13.

Two papers on influenza vaccine effectiveness (VE) were recently published. Last week, Canadian researchers published final VE estimates for the 2014-15 season reporting historically low VE of <10% and investigating possible reasons (cid.oxfordjournals.org/content/early/2016/03/29/cid.ciw176.abstract). Today, Belongia et al. published a meta-analysis of VE studies using the test-negative design showing considerable variation in VE by influenza type/subtype (www.thelancet.com/journals/laninf/article/PIIS1473-3099(16)00129-8/fulltext).

Prepared by BCCDC Influenza & Emerging Respiratory Pathogens Team

Report Disseminated: April 7, 2016

Provincial Health Services Authority
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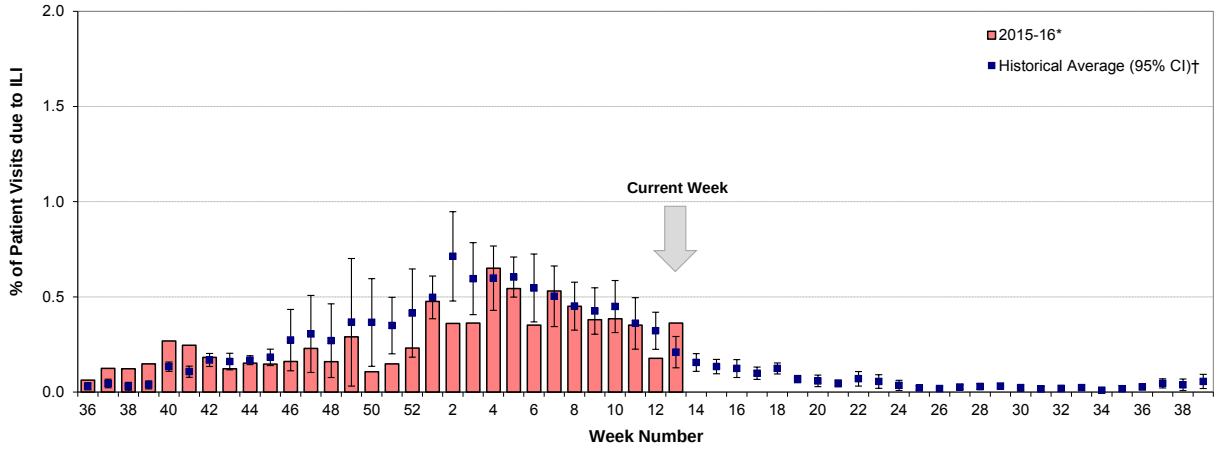
British Columbia

Sentinel Physicians

The proportion of patients with influenza-like illness (ILI) among those presenting to sentinel sites was significantly below the 10-year historical average at 0.18% in week 12 but significantly above the historical average at 0.36% in week 13. So far, 63% and 46% of sentinel sites have reported for weeks 12 and 13, respectively.

Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2015-16

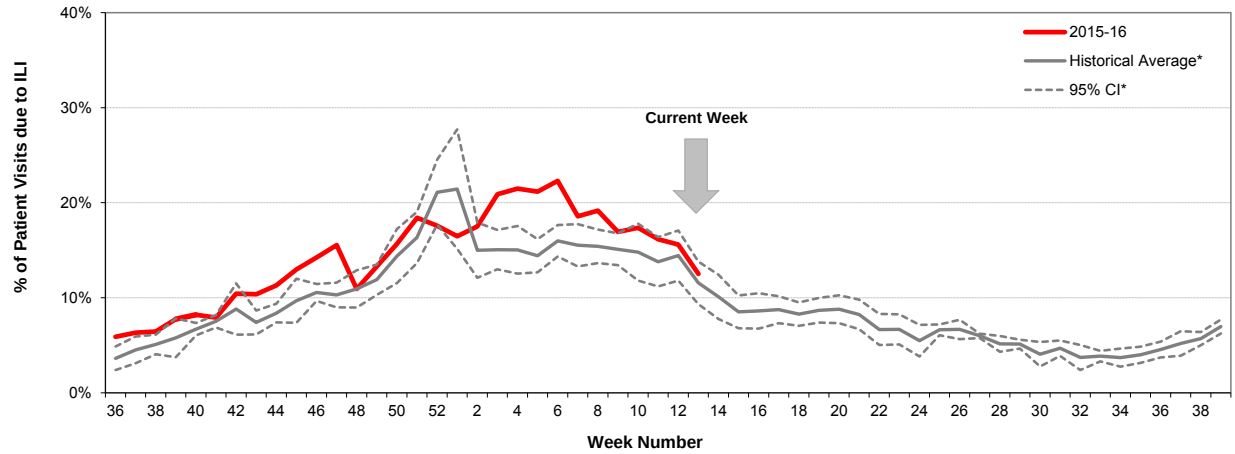


* Data are subject to change as reporting becomes more complete. One hospital ER site that reported ILI rates of ≥4% during weeks 7-9 was excluded from graph.
† 10-year historical average for 2015-16 season based on 2003-04 to 2014-15 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

BC Children's Hospital Emergency Room

The proportion of visits to BC Children's Hospital Emergency Room (ER) attributed to ILI continued a downward trend, falling from 16% in week 12 to 13% in week 13, and was consistent with the 5-year historical average for this time of year.

Percent of patients presenting to BC Children's Hospital ER attributed to influenza-like illness (ILI), British Columbia, 2015-16

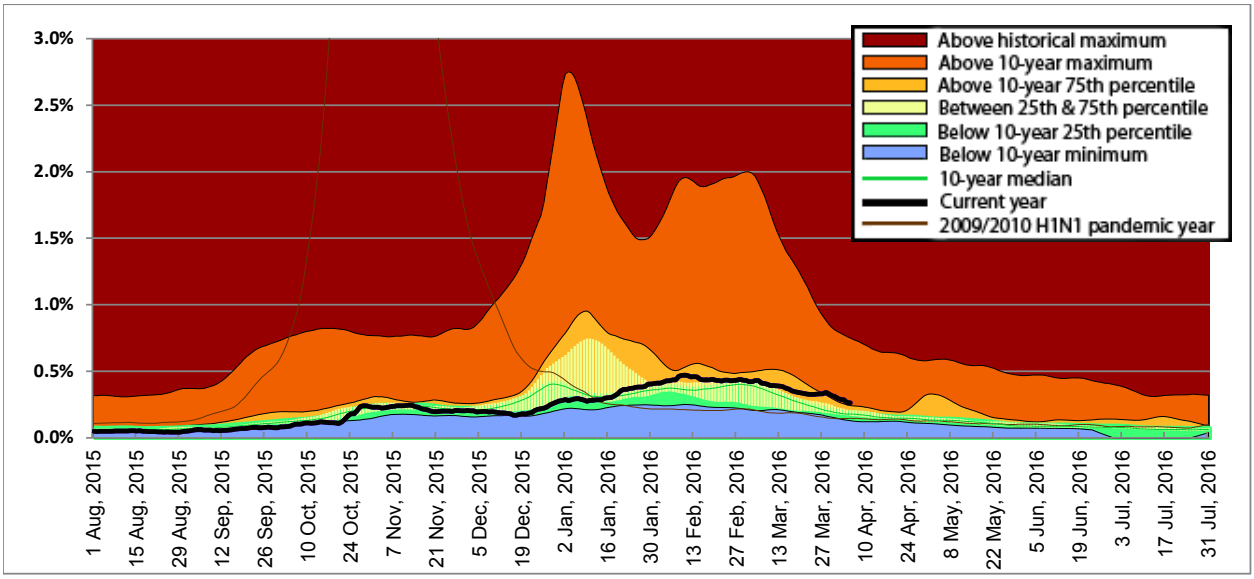


Source: BCCH Admitting, Discharge, Transfer database (ADT). Data includes records with a triage chieft complaint of "flu" or "influenza" or "fever/cough."
* 5-year historical average for 2015-16 season based on 2010-11 to 2014-15 seasons; CI=confidence interval

Medical Services Plan

BC Medical Services Plan (MSP) general practitioner claims for influenza illness (II), as a proportion of all submitted MSP claims, continued a steady decline in weeks 12-13. Rates remained above 10-year maximums in all Health Authorities and for the province overall, with the exception of FHA where rates were above 10-year 75th percentiles but below 10-year maximums and NHA where rates were within 10-year median values. Although rates were higher than historical levels for this time of year, this likely reflects the late start to the 2015-16 season; rates for this season continue to be lower than historical peak levels observed in previous seasons.

Service claims submitted to MSP for influenza illness (II)* as a proportion of all submitted general practitioner service claims, British Columbia, 2015-16

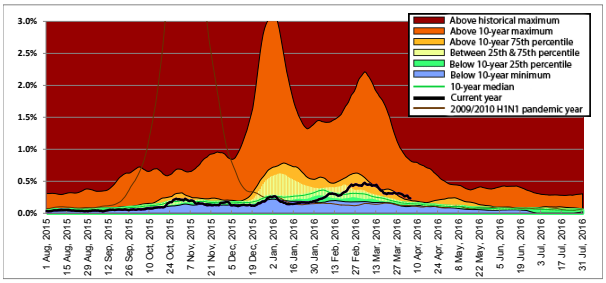


* Influenza illness is tracked as the percentage of all submitted MSP general practitioner claims with ICD-9 code 487 (influenza).

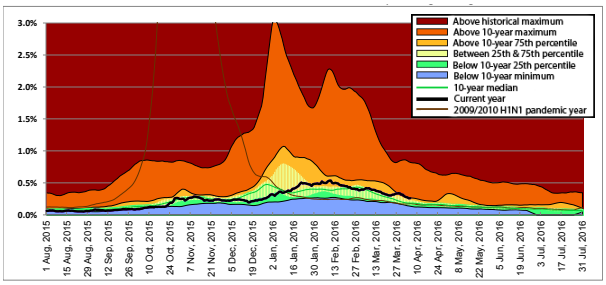
Data for the period August 1, 2009 to July 31, 2010 have been excluded from the 10-year median calculation due to atypical seasonality during the 2009/2010 H1N1 pandemic year. MSP week beginning August 1, 2015 corresponds to sentinel ILI week 30; data are current to April 5, 2016.

Data provided by Population Health Surveillance and Epidemiology, BC Ministry of Health Services.

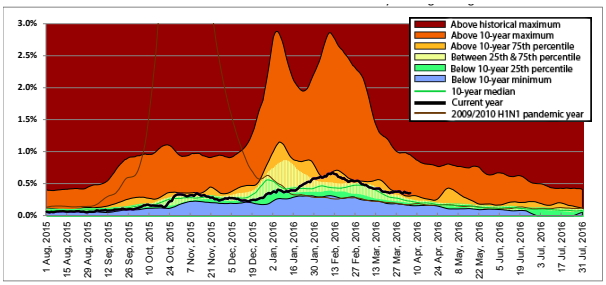
Interior



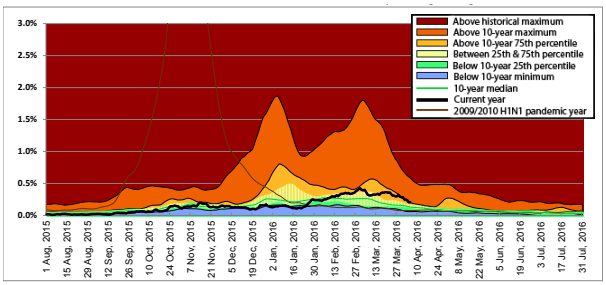
Fraser



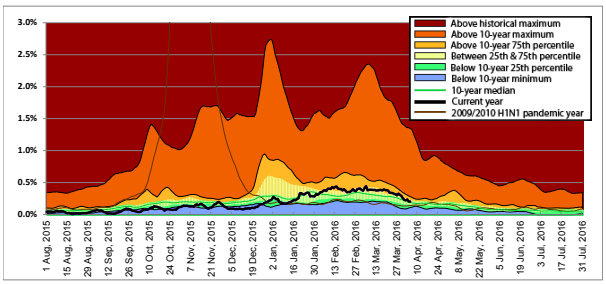
Vancouver Coastal



Vancouver Island



Northern



Laboratory Reports

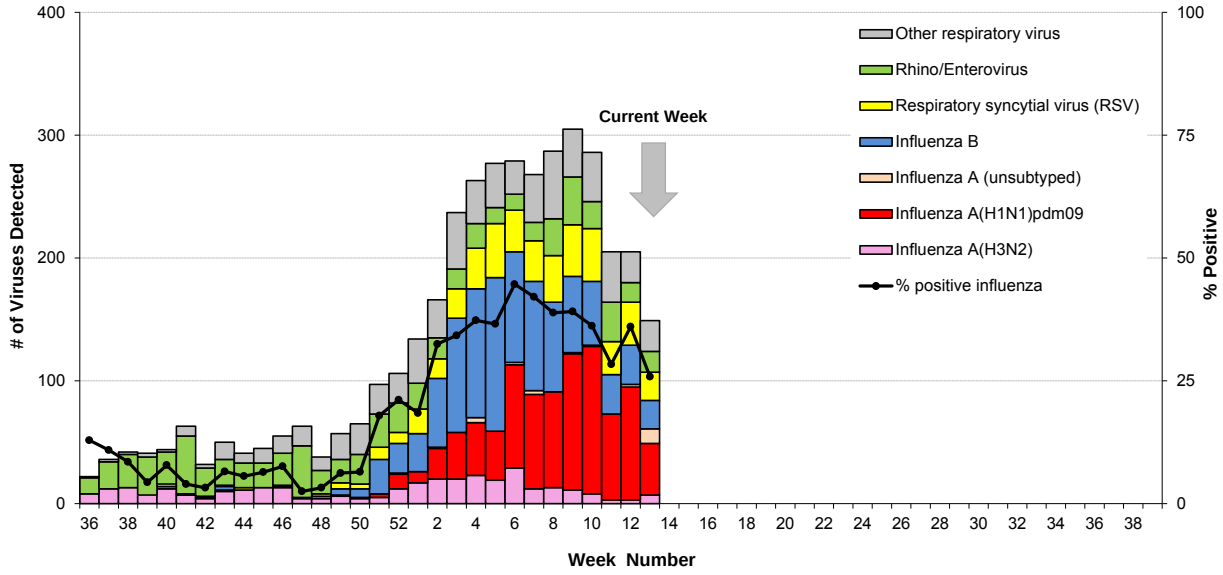
BCCDC Public Health Laboratory

In weeks 12-13, 675 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 209 (31%) tested positive for influenza, including 154 (74%) with influenza A [133 A(H1N1)pdm09, 10 A(H3N2), and 11 subtype pending] and 55 (26%) with influenza B. Since peaking at 45% in week 6, influenza positivity has continued a steady decline to 26% in week 13, with the exception of a spike in week 12 when influenza positivity again exceeded 30%. Influenza A(H1N1)pdm09 continued to be the predominant circulating influenza virus detected at the BCCDC PHL in weeks 12-13, comprising >60% of influenza detections with known type/subtype. Respiratory syncytial viruses (RSV) were also commonly detected during this period.

Cumulatively since week 40 (starting October 4, 2015), 2057 (27%) patients have tested positive for influenza at the BCCDC PHL, including 1133 (55%) with influenza A [835 A(H1N1)pdm09, 284 A(H3N2), and 14 subtype pending], 920 (45%) with influenza B, and four adult patients with influenza A and B co-infections. The 2015-16 season to date has been characterized by mixed circulation of influenza A and B viruses, with A(H1N1)pdm09 subtype viruses predominating over A(H3N2) subtype viruses since week 2 among influenza A detections and B/Victoria lineage viruses predominating over B/Yamagata lineage viruses among influenza B detections.

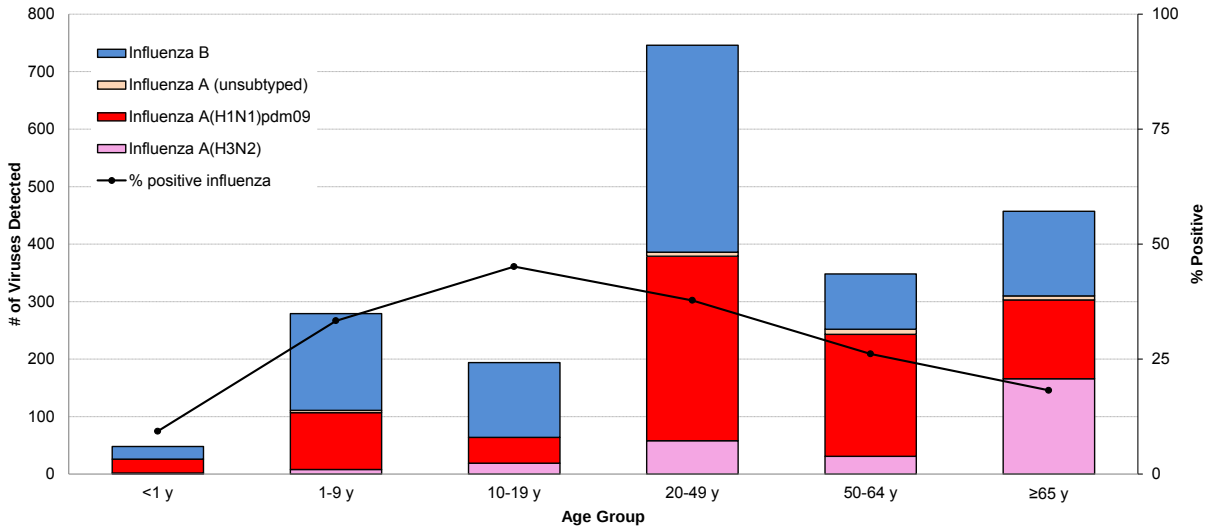
So far this season (cumulatively since week 40), just over one-half (53%) of influenza detections have been in non-elderly, working-aged adults 20-64 years, with a smaller proportion of detections in children <20 years (25%) and elderly adults ≥65 years (22%). However, this age distribution differs by influenza type/subtype: adults 20-64 years, and to a lesser extent children <20 years, comprise a larger proportion of A(H1N1)pdm09 and influenza B cases, while elderly adults ≥65 years comprise a larger proportion of A(H3N2) cases.

Influenza and other virus detections among respiratory specimens submitted to BCCDC Public Health Laboratory, 2015-16



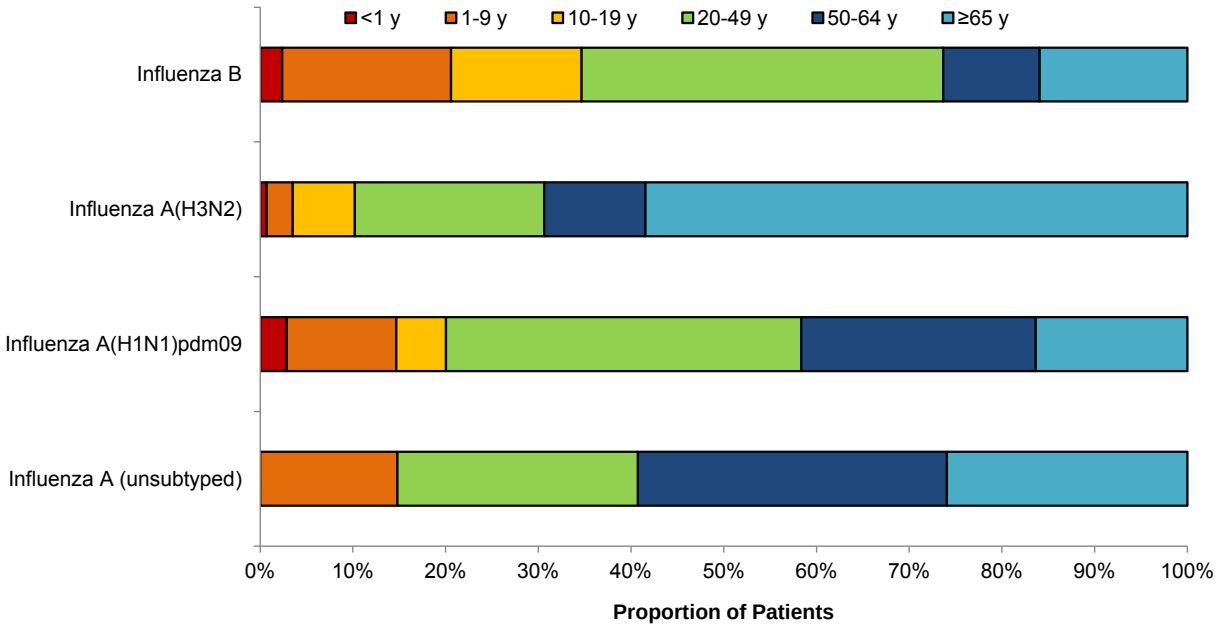
Data are current to April 6, 2016.

Cumulative number (since week 40) of influenza detections by type/subtype and age group, BCCDC Public Health Laboratory, 2015-16



Data are current to April 6, 2016; figure includes cumulative influenza detections for specimens collected from weeks 40-13.

Age distribution of influenza detections (cumulative since week 40) by type/subtype, BCCDC Public Health Laboratory, 2015-16

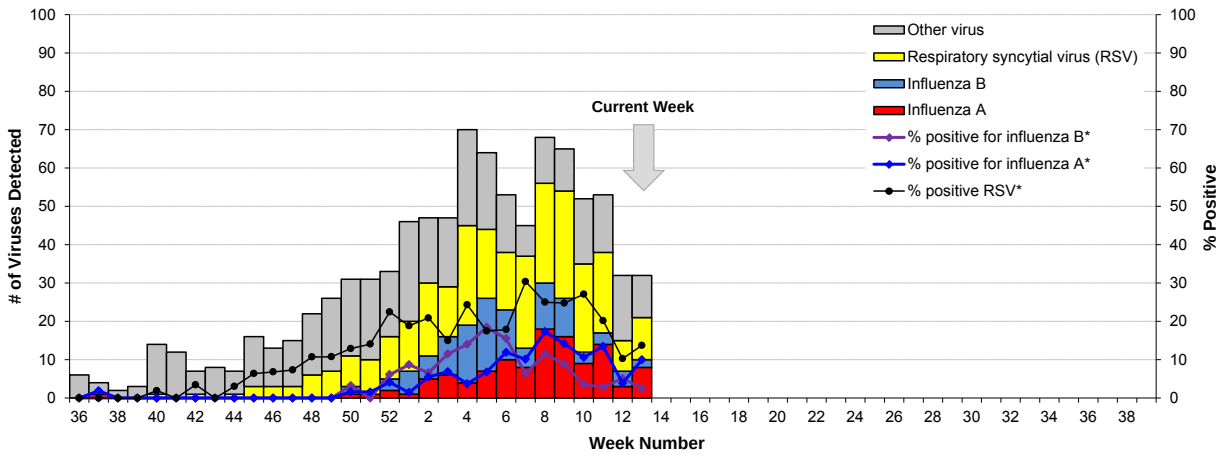


Data are current to April 6, 2016; figure includes cumulative influenza detections for specimens collected from weeks 40-13.

BC Children's and Women's Health Centre Laboratory

In weeks 12-13, the BC Children's and Women's Health Centre Laboratory conducted 158 tests for influenza; 11 (7%) were positive for influenza A, and 6 (4%) were positive for influenza B. Respiratory syncytial viruses (RSV) were also commonly detected during this period.

Influenza and other virus detections among respiratory specimens submitted to BC Children's and Women's Health Centre Laboratory, 2015-16



* Positive rates were calculated using aggregate data. The denominators for each rate represent the total number of tests; multiple tests may be performed for a single specimen and/or patient.

Influenza-like Illness (ILI) Outbreaks

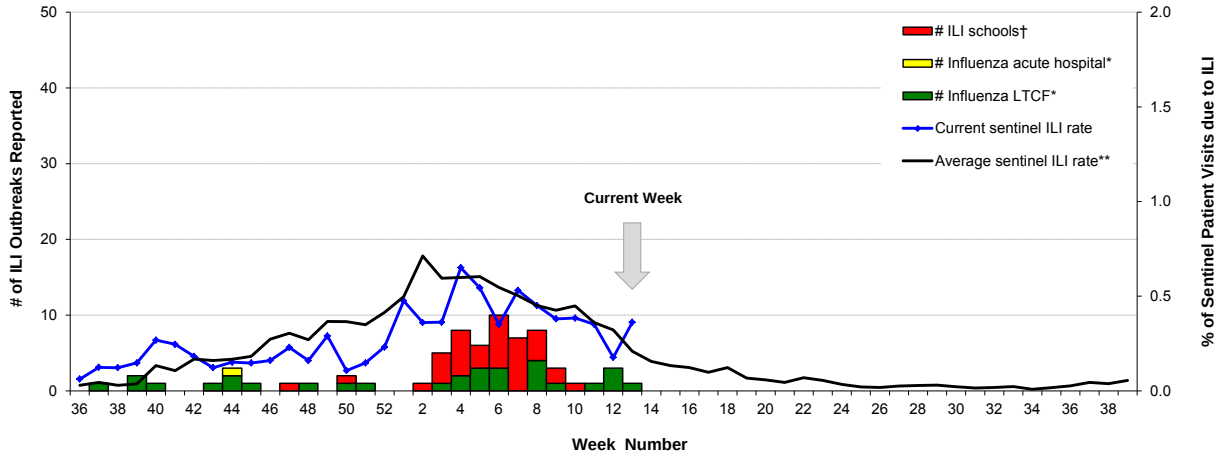
Since our last bulletin 2 weeks ago, 5 new lab-confirmed influenza outbreaks were reported: 2 in long-term care facilities (LTCFs) with A(H1N1)pdm09 detected (1 in IHA with onset in week 12 and 1 in FHA with onset in week 13); 2 in LTCFs with influenza B detected (1 in FHA and 1 in IHA, both with onset in week 12); and 1 in a rehabilitation facility with A(H3N2) detected in VCHA with onset in week 13 (not shown on graph). No new ILI outbreaks in schools were reported in weeks 12-13.

In total since mid-August (since week 32, starting August 9, 2015), 34 influenza outbreaks have been reported from facilities, including 31 from LTCFs, 1 from an acute care facility, and 2 from rehabilitation facilities:

- 17 with influenza A(H3N2) detected;
- 4 with influenza A(H1N1)pdm09 detected;
- 2 with both influenza A(H3N2) and A(H1N1)pdm09 detected;
- 2 with both influenza A(H3N2) and B detected; and
- 9 with influenza B detected.

Thirty-seven school ILI outbreaks have been reported so far this season.

Number of influenza-like illness (ILI) outbreaks reported, compared to current sentinel ILI rate and historical average sentinel ILI rate, British Columbia 2015-16



* Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one **laboratory-confirmed** case of influenza.
† School-based ILI outbreak defined as >10% absenteeism on any day, most likely due to ILI.
** 10-year historical average for 2015-16 season based on 2003-04 to 2014-15 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality.

Updated AMMI Guidelines: LTCF Outbreak Control

In December 2015, the Association of Medical Microbiology and Infectious Disease (AMMI) Canada posted updated recommendations for influenza antiviral drug treatment and prophylaxis for the 2015-16 season, notably in relation to control of influenza outbreaks in long-term care facilities, available from www.ammi.ca/guidelines.

National

FluWatch (week 12, March 20-26, 2016)

For the second consecutive week, influenza activity continued to decrease across Canada. All reporting regions reported sporadic or localized activity. In week 12, the number of positive influenza B tests reported continued to increase, but still accounted for only 30% of positive influenza tests. Overall, the percentage of tests positive for influenza continued to decrease, from 31% in week 11 to 30% in week 12, still above the five-year expected levels for this time of year (range: 11-20%). However, with the late start to the 2015-16 influenza season, these above-normal levels are not unexpected and are typical of peak season levels. In week 12, adults 65 years and older accounted for the largest proportion of hospitalizations in week 12 and account for the largest proportion of hospitalizations to date this season. Hospitalizations, ICU admissions and deaths among the pediatric population, while declining, remain above expected levels based on the past several influenza seasons. The number of outbreaks reported in week 12 was similar to the previous week, with half of the outbreaks reported in long-term care facilities. Details are available at: healthycanadians.gc.ca/diseases-conditions-maladies-affections/disease-maladie/flu-grippe/surveillance/fluwatch-reports-rapports-surveillance-influenza-eng.php.

National Microbiology Laboratory (NML): Strain Characterization

From September 1, 2015 to April 7, 2016, the National Microbiology Laboratory (NML) received 1442 influenza viruses [159 A(H3N2), 857 A(H1N1)pdm09 and 426 B] from Canadian laboratories for antigenic characterization.

Influenza A(H3N2): Of the 159 influenza A(H3N2) viruses, only 40 (25%) had sufficient haemagglutination titre for antigenic characterization by haemagglutination inhibition (HI) assay. Of the 40 viruses characterized by HI assay, all were considered antigenically similar to cell-passaged A/Switzerland/9715293/2013, the WHO-recommended A(H3N2) component for the 2015-16 northern hemisphere influenza vaccine. Genetic characterization was performed to infer antigenic properties on the remaining 119 viruses that did not grow to sufficient haemagglutination titre for HI assay. Of the 119 A(H3N2) viruses genetically characterized, all were reported to belong to a genetic group in which most viruses were antigenically related to A/Switzerland/9715293/2013.

Influenza A(H1N1)pdm09: The 857 A(H1N1)pdm09 viruses characterized were antigenically similar to A/California/7/2009, the WHO-recommended A(H1N1) component for the 2015-16 northern hemisphere influenza vaccine.

Influenza B: Of the 426 influenza B viruses characterized, 112 (26%) were antigenically similar to B/Phuket/3073/2013 (Yamagata lineage), the recommended influenza B component for the 2015-16 northern hemisphere influenza vaccine, while 314 (74%) were characterized as B/Brisbane/60/2008 (Victoria lineage), the recommended influenza B component for the 2015-16 northern hemisphere quadrivalent influenza vaccine containing two influenza B components.

National Microbiology Laboratory (NML): Antiviral Resistance

From September 1, 2015 to April 7, 2016, the NML received influenza viruses from Canadian laboratories for drug susceptibility testing. Of the 1027 influenza A viruses [173 A(H3N2) and 854 A(H1N1)pdm09] tested against amantadine, all were resistant with the exception of one A(H3N2) virus which was sensitive to amantadine. Of the 976 influenza viruses [139 A(H3N2), 600 A(H1N1)pdm09 and 237 B] tested against oseltamivir, all A(H3N2) and B viruses and 593/600 (99%) A(H1N1)pdm09 viruses were sensitive; seven A(H1N1)pdm09 viruses with a H275Y mutation were resistant. Of the 979 influenza viruses [139 A(H3N2), 603 A(H1N1)pdm09 and 237 B] tested against zanamivir, all were sensitive.

International

USA (week 12, March 20-26, 2016)

During week 12, influenza activity decreased slightly, but remained elevated in the United States. The most frequently identified influenza virus type reported by public health laboratories during week 12 was influenza A, with influenza A(H1N1)pdm09 viruses predominating. The percentage of respiratory specimens testing positive for influenza in clinical laboratories decreased. The proportion of deaths attributed to pneumonia and influenza (P&I) was below the system-specific epidemic threshold in the NCHS Mortality Surveillance System and above the system-specific epidemic threshold in the 122 Cities Mortality Reporting System. Three influenza-associated paediatric deaths were reported. A cumulative rate for the season of 21.4 laboratory-confirmed influenza-associated hospitalizations per 100,000 population was reported. The proportion of outpatient visits for influenza-like illness (ILI) was 2.9%, which is above the national baseline of 2.1%. The geographic spread of influenza in 29 states was reported as widespread, 18 states reported regional activity, two states reported local activity, and one state reported sporadic activity. Details are available at: www.cdc.gov/flu/weekly/.

WHO (April 4, 2016)

Globally, elevated levels of influenza activity continued to be reported in North America, in parts of Europe and in Northern Temperate Asia. An increase in influenza B virus activity has been reported in Northern Temperate Asia, South East Asia and Europe.

- In North America, influenza activity has peaked and remained elevated with influenza A(H1N1)pdm09 virus predominating. Canada reported increased detections of influenza B virus.
- In Europe, high level of influenza activity was still reported with increasing detections of influenza B virus. In most countries influenza activity seemed to have peaked.
- Northern Temperate Asia continued to report ongoing and elevated levels of influenza with increasing proportions of influenza B.
- In western Asia, influenza activity continued to decline as seen in previous reporting weeks.
- In Central America and the Caribbean, Jamaica reported elevated severe acute respiratory illness (SARI) activity associated with influenza A(H1N1)pdm09 virus infection. High influenza activity due to influenza A(H1N1)pdm09 was reported in Guatemala.
- In tropical South America, influenza activity in Brazil continued to remain high with influenza A(H1N1)pdm09 predominating. Elevated SARI activity associated with respiratory syncytial virus (RSV) infection was reported in Ecuador.
- In the temperate countries of the Southern Hemisphere influenza virus activity remained low.
- From March 7 to 20, 2016, the WHO GISRS laboratories tested more than 138,525 specimens, of which 40,448 were positive for influenza viruses: 24,973 (62%) were typed as influenza A and 15,475 (38%) as influenza B. Of the sub-typed influenza A viruses, 10,087 (88%) were influenza A(H1N1)pdm09 and 1442 (13%) were influenza A(H3N2). Of the characterized B viruses, 862 (18%) belonged to the B/Yamagata lineage and 3,836 (82%) to the B/Victoria lineage.

Details are available at: www.who.int/influenza/surveillance_monitoring/updates/en/.

On February 8, 2016, the WHO published a Risk Assessment on Seasonal Influenza A(H1N1)pdm09, available from: www.who.int/influenza/publications/riskassessment_AH1N1pdm09_201602/en/.

Influenza Vaccine Effectiveness

2014-15 Influenza Vaccine Effectiveness Evaluation, Canada

Last week, the Canadian Sentinel Practitioner Surveillance Network (SPSN) published final, end-of-season estimates of vaccine effectiveness (VE) for the 2014-15 season in the journal *Clinical Infectious Diseases*. Overall VE against medically attended illness due to any influenza type/subtype was <10%, the lowest VE reported in over a decade of monitoring by the Canadian SPSN. The 2014-15 vaccine provided no protection against dominant A(H3N2) viruses that were antigenically drifted (i.e. mismatched to vaccine), with estimated VE of -17% (95% CI: -50% to 9%). More moderate and significant VE was found for influenza B viruses that were lineage-level matched but clade-level mismatched to vaccine at 45% (95% CI: 18% to 64%), although this VE estimate was also lower than expected. The authors propose that a convergence of conditions may have contributed to the historically low vaccine protection observed during the 2014-15 season, including genetic and antigenic drift in circulating viruses, the use of unchanged vaccine components from the prior 2013-14 season, and potential negative effects of prior repeat vaccination.

For details see: cid.oxfordjournals.org/content/early/2016/03/29/cid.ciw176.abstract.

Meta-analysis of Influenza Vaccine Effectiveness Studies Using the Test-Negative Design

This week, a team of researchers led by Dr. Edward Belongia published a landmark study in the journal *Lancet Infectious Diseases*. Dr. Belongia and colleagues conducted a systematic review and meta-analysis of vaccine effectiveness (VE) studies published from January 1, 2004 to March 31, 2015 using the test-negative design among outpatients with PCR-confirmed influenza. Pooled VE varied considerably by influenza type/subtype for current seasonal influenza vaccine components, ranging from 33% (95% CI: 26% to 39%) for A(H3N2), to 54% (95% CI: 46% to 61%) for influenza B and 61% (95% CI: 57 to 65%) for A(H1N1)pdm09 components.

For details see: www.thelancet.com/journals/laninf/article/PIIS1473-3099(16)00129-8/abstract.

WHO Recommendations for Influenza Vaccines

WHO Recommendations for 2016-17 Northern Hemisphere Influenza Vaccine

On February 25, 2016, the WHO announced recommended strain components for the 2016-17 Northern Hemisphere trivalent influenza vaccine (TIV):*

- an A/California/7/2009 (H1N1)pdm09-like virus;†
- an A/Hong Kong/4801/2014(H3N2)-like virus;‡
- a B/Brisbane/60/2008-like (Victoria-lineage) virus.§

It is recommended that quadrivalent influenza vaccines (QIV) containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like (Yamagata-lineage) virus.

These recommended components are the same as those recommended for the 2016 Southern Hemisphere vaccine.

* Recommended strains represent a change for two of the three components used for the 2015-16 Northern Hemisphere vaccines.

† Recommended strain has been retained as the A(H1N1) component since the 2009 pandemic and has been included in the Northern Hemisphere vaccine since 2010-11.

‡ Recommended strain for the A(H3N2) component represents a phylogenetic clade-level change from a clade 3C.3a virus to a clade 3C.2a virus.

§ Recommended strain for the influenza B component represents a lineage-level change from a B/Yamagata-lineage virus to a B/Victoria-lineage virus.

For further details: http://www.who.int/influenza/vaccines/virus/recommendations/2016_17_north/en/.

WHO Recommendations for 2015-16 Northern Hemisphere Influenza Vaccine

On February 26, 2015, the WHO announced the recommended strain components for the 2015-16 Northern Hemisphere trivalent influenza vaccine (TIV):*

- an A/California/7/2009(H1N1)pdm09-like virus;†
- an A/Switzerland/9715293/2013(H3N2)-like virus;‡
- a B/Phuket/3073/2013-like (Yamagata-lineage) virus.§

It is recommended that quadrivalent influenza vaccines (QIV) containing two influenza B viruses contain the above three viruses and a B/Brisbane/60/2008-like (Victoria-lineage) virus.

* These recommended strains are the same as those used for the 2015 Southern Hemisphere vaccine.

† Recommended strain has been retained as the A(H1N1) component since the 2009 pandemic and has been included in the Northern Hemisphere vaccine since 2010-11.

‡ A/South Australia/55/2014, A/Norway/466/2014, and A/Stockholm/6/2014 are A/Switzerland/9715293/2013-like viruses. Recommended strain is considered antigenically distinct from the A/Texas/50/2012-like virus recommended for the 2014-15 Northern Hemisphere vaccine and clusters within the emerging phylogenetic clade 3C.3a.

§ Recommended strain is the same influenza B-Yamagata lineage as the B/Massachusetts/2/2012-like virus recommended for the 2014-15 Northern Hemisphere vaccine but represents a phylogenetic clade-level change from clade 2 to clade 3.

For further details: www.who.int/influenza/vaccines/virus/recommendations/2015_16_north/en/.

Additional Information

Explanatory Note:

The surveillance period for the 2015-16 influenza season is defined starting in week 40. Weeks 36-39 of the 2014-15 season are shown on graphs for comparison purposes.

List of Acronyms:

ACF: Acute Care Facility
AI: Avian influenza
FHA: Fraser Health Authority
HBoV: Human bocavirus
HMPV: Human metapneumovirus
HSDA: Health Service Delivery Area
IHA: Interior Health Authority
ILI: Influenza-Like Illness
LTCF: Long-Term Care Facility
MSP: BC Medical Services Plan
NHA: Northern Health Authority
NML: National Microbiological Laboratory
A(H1N1)pdm09: Pandemic H1N1 influenza (2009)
RSV: Respiratory syncytial virus
VCHA: Vancouver Coastal Health Authority
VIHA: Vancouver Island Health Authority
WHO: World Health Organization

Current AMMI Canada Guidelines on the Use of Antiviral Drugs for Influenza:
www.ammi.ca/guidelines

Web Sites:

BCCDC Emerging Respiratory Pathogen Updates:
www.bccdc.ca/health-professionals/data-reports/emerging-respiratory-virus-updates

Influenza Web Sites

Canada – Flu Watch: www.phac-aspc.gc.ca/fluwatch/
Washington State Flu Updates: http://www.doh.wa.gov/portals/1/documents/5100/420-100-fluupdate.pdf
USA Weekly Surveillance Reports: www.cdc.gov/flu/weekly/
European Influenza Surveillance Scheme:
ecdc.europa.eu/EN/HEALTHTOPICS/SEASONAL_INFLUENZA/EPIDEMIOLOGICAL_DATA/Pages/Weekly_Influenza_Surveillance_Overview.aspx
WHO – Weekly Epidemiological Record: www.who.int/wer/en/
WHO Collaborating Centre for Reference and Research on Influenza (Australia):
www.influenzacentre.org/
Australian Influenza Report:
www.health.gov.au/internet/main/publishing.nsf/content/cda-surveil-ozflu-flucurr.htm
New Zealand Influenza Surveillance Reports: www.surv.esr.cri.nz/virology/influenza_weekly_update.php

Avian Influenza Web Sites

WHO – Influenza at the Human-Animal Interface: www.who.int/csr/disease/avian_influenza/en/
World Organization for Animal Health: www.oie.int/eng/en_index.htm

Contact Us:

Tel: (604) 707-2510
Fax: (604) 707-2516
Email: InfluenzaFieldEpi@bccdc.ca

Communicable Disease Prevention and Control Services (CDPACS)
BC Centre for Disease Control
655 West 12th Ave, Vancouver BC V5Z 4R4

Online: www.bccdc.ca/health-professionals/data-reports/influenza-surveillance-reports

version: 26 Oct 2011

Influenza-Like Illness (ILI) Outbreak Summary Report Form

Please complete and email to ilioutbreak@bccdc.ca

Note: This form is for provincial surveillance purposes.
Please notify your local health unit per local guidelines/requirements.

ILI: Acute onset of respiratory illness with fever and cough and with one or more of the following: sore throat, arthralgia, myalgia, or prostration which *could* be due to influenza virus. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.

Schools and work site outbreak: greater than 10% absenteeism on any day, most likely due to ILI.

Residential institutions (facilities) outbreak: two or more cases of ILI within a seven-day period.

A — Reporting Information

Health unit/medical health officer notified? ☐ *Yes* ☐ *No*

Person Reporting: _____ Title: _____

Contact Phone: _____ Email: _____

Health Authority: _____ HSDA: _____

Full Facility Name: _____

Is this report:

☐ First Notification *(complete section **B** below; Section **D** if available)*

☐ Update *(complete section **C** below; Section **D** if available)*

☐ Outbreak Over *(complete section **C** below; Section **D** if available)*

B — First Notification

Type of facility: ☐ LTCF ☐ Acute Care Hospital ☐ Senior's Residence

(if ward or wing, please specify name/number: _____)

☐ Workplace ☐ School (grades:) ☐ Other (_____)

Date of onset of first case of ILI (dd/mm/yyyy): DD / MMM / YYYY

Numbers to date	Residents/Students	Staff
Total		
With ILI		
Hospitalized		
Died		

C — Update AND Outbreak Declared Over

Date of onset for most recent case of ILI (dd/mm/yyyy): DD / MMM / YYYY

If over, date outbreak declared over (dd/mm/yyyy): DD / MMM / YYYY

Numbers to date	Residents/Students	Staff
Total		
With ILI		
Hospitalized		
Died		

D — Laboratory Information

Specimen(s) submitted? ☐ Yes (location: _____) ☐ No ☐ Don't know

If yes, organism identified? ☐ Yes (specify: _____) ☐ No ☐ Don't know

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