

British Columbia Influenza Surveillance Bulletin

Influenza Season 2016-17, Number 21, Weeks 16-17

April 16 to 29, 2017

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End-of-season Summary: 2016-17 Influenza Season

The 2016-17 influenza season in BC was characterized by intense and dominant A(H3N2) activity, with low-level, late-season circulation of influenza B viruses.

At the BCCDC Public Health Laboratory (PHL), influenza positivity this season peaked around weeks 52-3 (exceeding 40%), with influenza A(H3N2) viruses comprising >95% of influenza detections during this peak period. Influenza B became, as of week 10, the dominant influenza virus detected at the BCCDC PHL albeit at lower levels than peak A(H3N2) activity.

Elderly adults ≥ 65 years old comprised the majority of influenza detections, related in part to the dominant A(H3N2) activity and record number of facility outbreaks this season. Younger age groups were also represented, notably among influenza B detections.

As in 2014-15, the last dominant A(H3N2) season, a record number of influenza outbreaks in long-term care facilities (LTCF) were reported this season. The cumulative tally of LTCF influenza outbreaks reported to date this season ($n=200$) exceeded the prior full-season historic record in 2014-15 ($n=165$, weeks 40-17). In both seasons, most reported outbreaks were associated with influenza A(H3N2).

This will be the final regular influenza surveillance bulletin of the 2016-17 season. Further bulletins will be issued as needed until the next regular reporting period begins for the 2017-18 season.

Prepared by BCCDC Influenza & Emerging Respiratory Pathogens Team

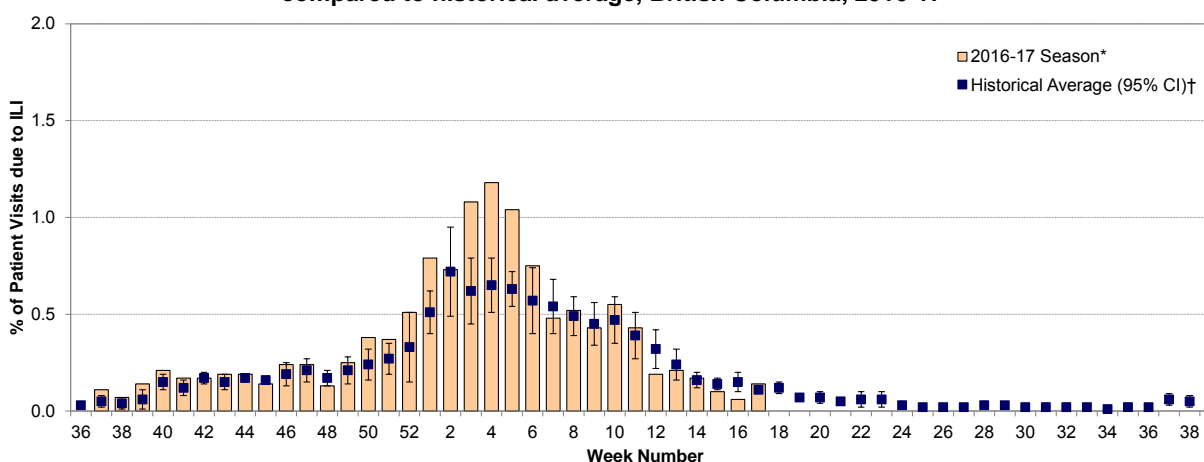
Report Disseminated: May 5, 2017

British Columbia

Sentinel Physicians

During the 2016-17 season, the proportion of patients with influenza-like illness (ILI) among those presenting to sentinel sites peaked in weeks 3-5 and was significantly above the 10-year historical average during this period. Otherwise, rates were generally consistent with historical ranges. In weeks 16-17, the proportion of visits continued to decrease. So far, 60% and 50% of sites have reported data for weeks 16 and 17, respectively; rates are subject to change as reporting becomes more complete.

Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2016-17

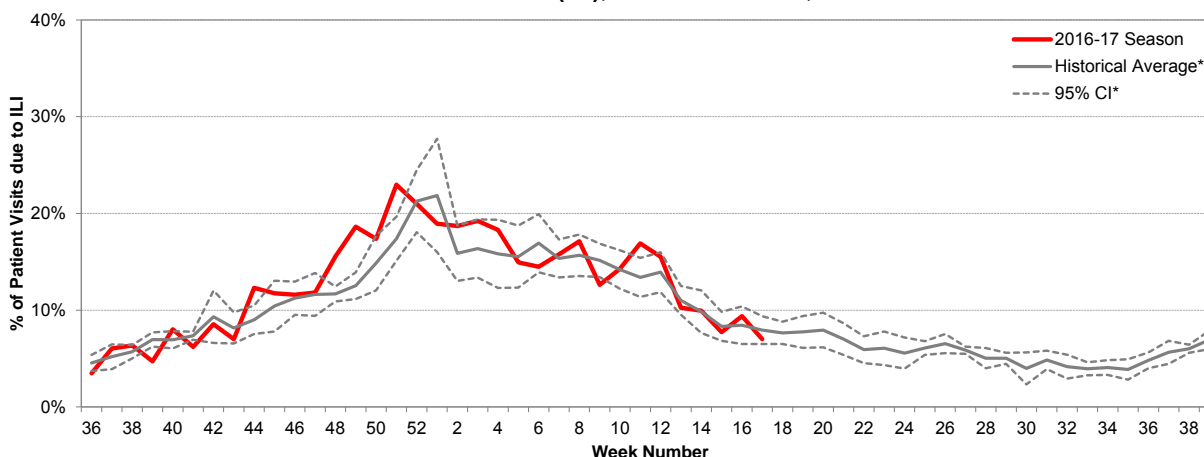


* Data are subject to change as reporting becomes more complete. One hospital ER site that reported ILI rates $\geq 5\%$ was excluded from the graph.
† 10-year historical average for 2016-17 season based on 2004-05 to 2015-2016 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

BC Children's Hospital Emergency Room

During the 2016-17 season, the proportion of visits to BC Children's Hospital Emergency Room (ER) attributed to ILI peaked at slightly above 20% in weeks 51-52, roughly consistent with the historical average for the past 5 seasons. In weeks 16-17, ER visits attributable to ILI continued to decline to 7-9%.

Percent of patients presenting to BC Children's Hospital ER attributed to influenza-like illness (ILI), British Columbia, 2016-17



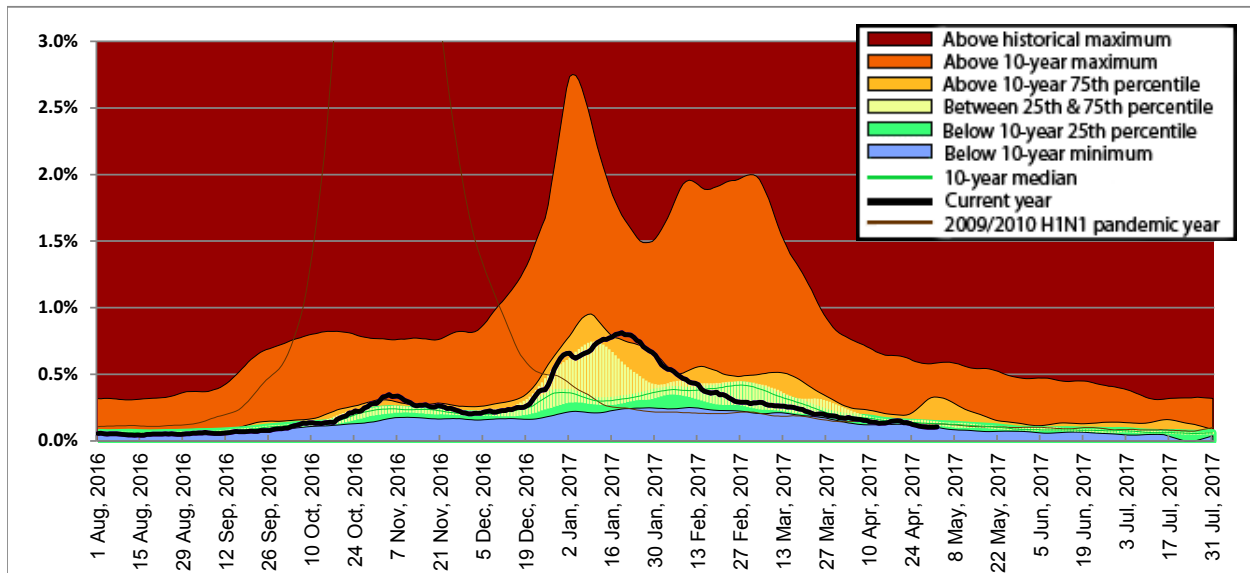
Source: BCCCH Admitting, Discharge, Transfer database (ADT). Data includes records with a triage chief complaint of "flu" or "influenza" or "fever/cough."
* 5-year historical average for 2016-17 season based on 2011-12 to 2015-16 seasons; CI=confidence interval.

Medical Services Plan

During the 2016-17 season, BC Medical Services Plan (MSP) general practitioner claims for influenza illness (II), as a proportion of all submitted MSP claims, increased sharply beginning in week 51, peaked in weeks 3-4 and gradually declined thereafter. Overall, provincial MSP rates exceeded expected seasonal values during the peak period compared to historical data for the past 10 years. Some expected regional variation in the timing and intensity of II activity was observed across health authorities, notably in NHA where no discernable peak occurred during the 2016-17 season.

In weeks 16-17, MSP rates were at or below expected median levels for the province overall and in all regional health authorities.

Service claims submitted to MSP for influenza illness (II)* as a proportion of all submitted general practitioner service claims, British Columbia, 2016-17

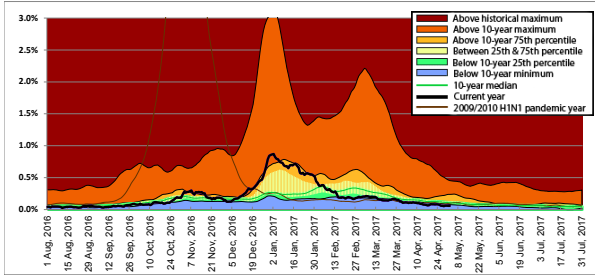


* Influenza illness is tracked as the percentage of all submitted MSP general practitioner claims with ICD-9 code 487 (influenza).

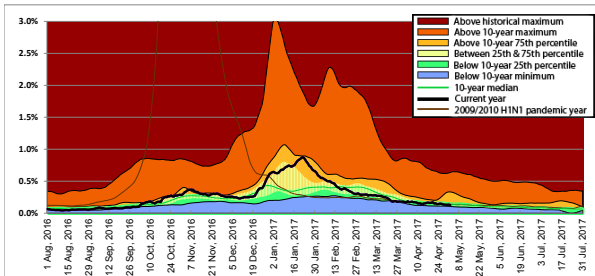
Data for the period August 1, 2009 to July 31, 2010 have been excluded from the 10-year median calculation due to atypical seasonality during the 2009/2010 H1N1 pandemic year. MSP week beginning August 1, 2016 corresponds to sentinel ILI week 31; data are current to May 2, 2017.

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

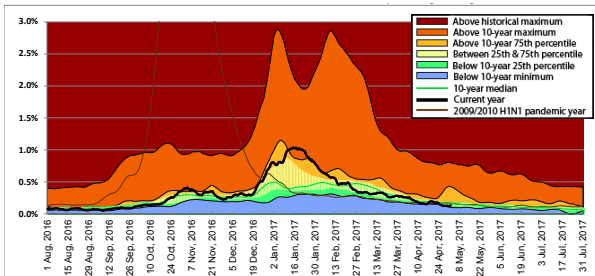
Interior



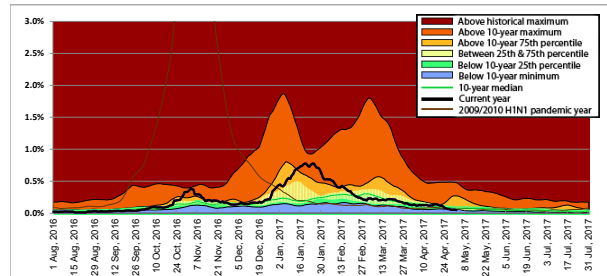
Fraser



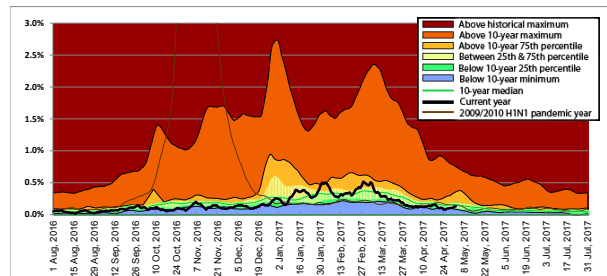
Vancouver Coastal



Vancouver Island



Northern



Laboratory Reports

BCCDC Public Health Laboratory

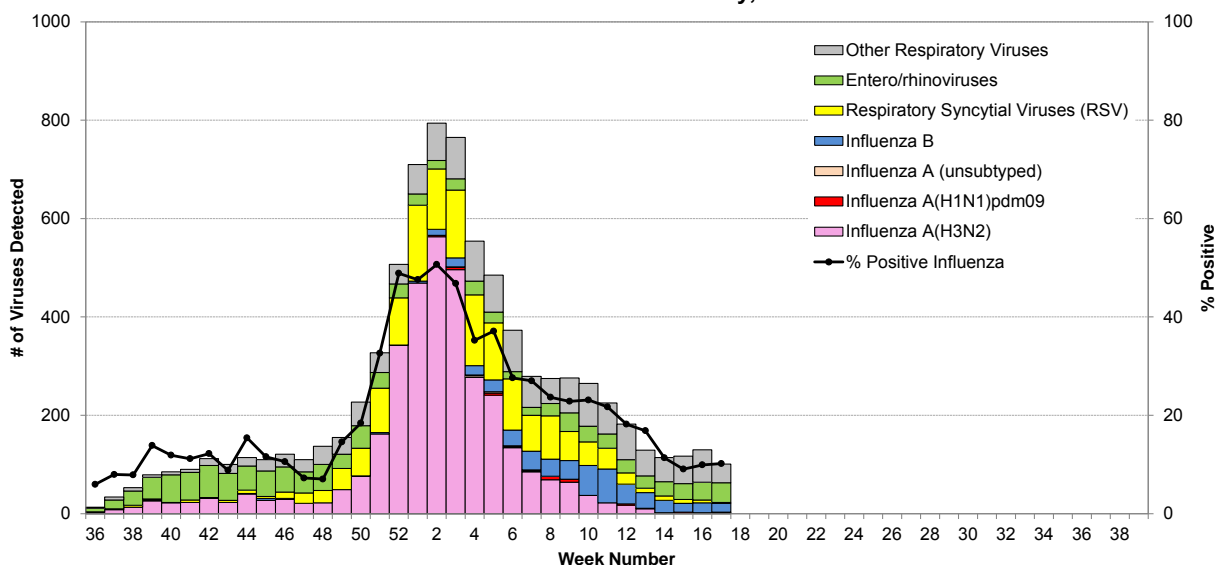
During the 2016-17 season (cumulatively since week 40, starting October 2, 2016), 3877 (31%) patients tested positive for influenza at the BCCDC Public Health Laboratory (PHL), including 3363 (87%) with influenza A [3320 A(H3N2), 41 A(H1N1)pdm09 and 2 subtype pending], 511 (13%) with influenza B and 3 patients who had both influenza A and B detected during the season.

The 2016-17 season was characterized by dominant influenza A(H3N2) activity. Overall influenza positivity at the BCCDC PHL began to increase in week 49, peaking around weeks 52-3 when positivity rates exceeded 40%. Influenza A(H3N2) viruses comprised >95% of influenza detections during this peak period. Low-level influenza B activity was observed near the tail-end of the season starting around week 6, with the number of influenza B detections surpassing influenza A detections as of week 10.

Elderly adults ≥ 65 years old were disproportionately represented among influenza detections during the 2016-17 season, related in part to the dominant A(H3N2) activity and record number of long-term care facility (LTCF) outbreaks, although younger age groups were also affected. Adults 20-64 years old, and to a lesser extent children aged 1-19 years old, comprised a larger proportion of influenza B detections.

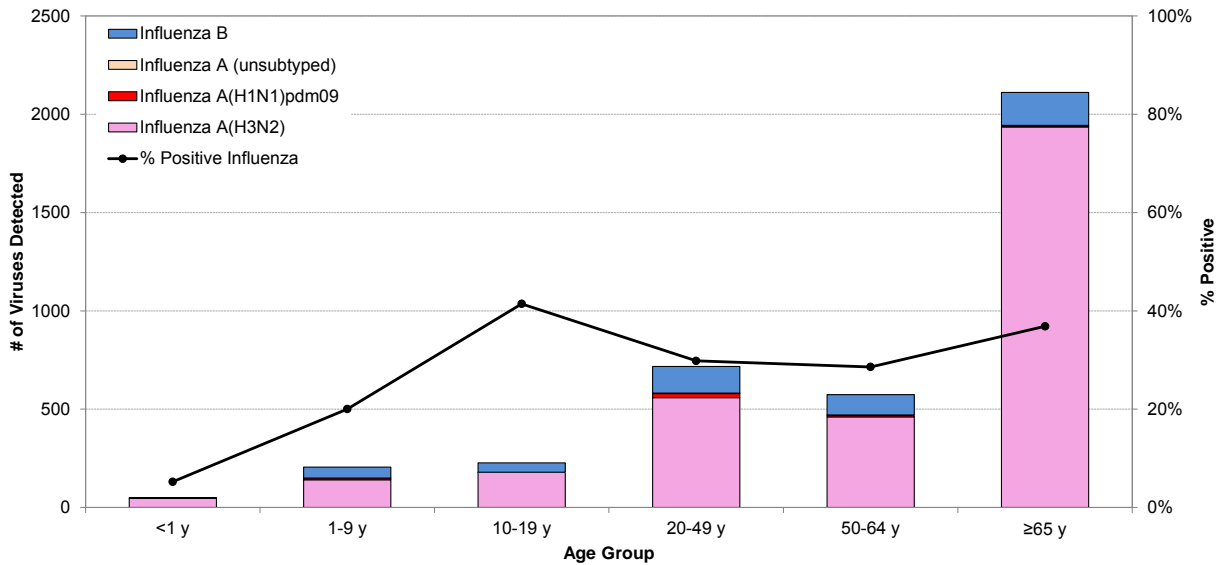
In weeks 16-17, 423 patients were tested for respiratory viruses at the BCCDC PHL. Of these, 43 (10%) tested positive for influenza including 5 (12%) with influenza A [4 A(H3N2) and 1 A(H1N1)pdm09] and 38 (88%) with influenza B. Overall influenza positivity remained stable around 10% in weeks 16-17. Influenza B viruses comprised the majority of influenza detections during this period, representing approximately 90% of all influenza detections.

Influenza and other virus detections among respiratory specimens submitted to BCCDC Public Health Laboratory, 2016-17



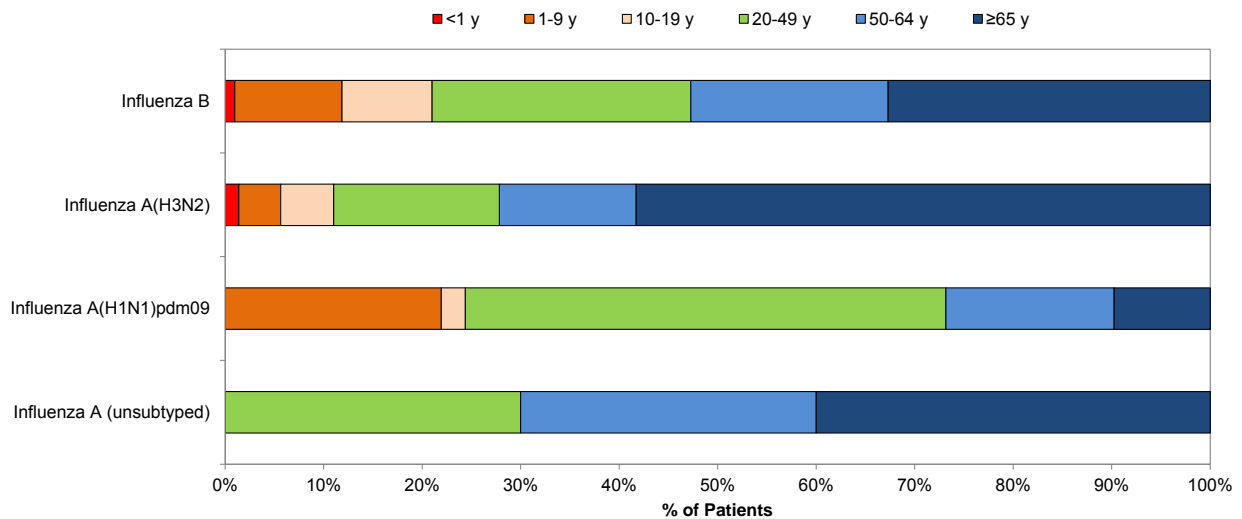
Data are current to May 3, 2017.

Cumulative number (since week 40) of influenza detections by type/subtype and age group, BCCDC Public Health Laboratory, 2016-17



Data are current to May 3, 2017; figure includes cumulative influenza detections for specimens collected from weeks 40-17.

Age distribution of influenza detections (cumulative since week 40), BCCDC Public Health Laboratory, 2016-17



Data are current to May 3, 2017; figure includes cumulative influenza detections for specimens collected from weeks 40-17.

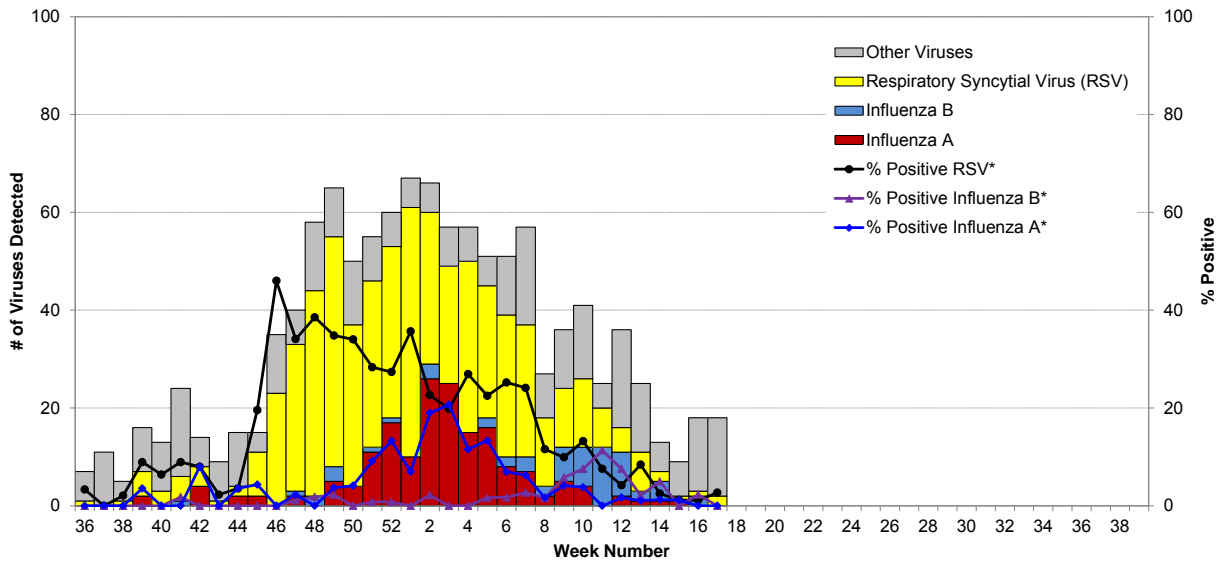
BC Children’s and Women’s Health Centre Laboratory

During the 2016-17 season (cumulatively since week 40, starting October 2, 2016), the BC Children’s and Women’s Health Centre Laboratory conducted 2898 tests for respiratory viruses. Of these, 170 (6%) were positive for influenza A and 65 (2%) were positive for influenza B. As with the BCCDC PHL data, influenza A activity peaked around weeks 2-3, with some low-level, late-season influenza B activity observed beginning around week 9.

Respiratory syncytial viruses (RSV) were the dominant respiratory virus detected at the BC Children’s and Women’s Health Centre Laboratory during the 2016-17 season with 559/2898 (19%) tests positive cumulatively during the season. RSV positivity was at or exceeded 20% from weeks 45-7.

In weeks 16-17, 161 tests for respiratory viruses were conducted at the BC Children’s and Women’s Health Centre Laboratory. Of these, 2 (1%) were positive for influenza B while none were positive for influenza A.

Influenza and other virus detections among respiratory specimens submitted to BC Children’s and Women’s Health Centre Laboratory, 2016-17



* 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

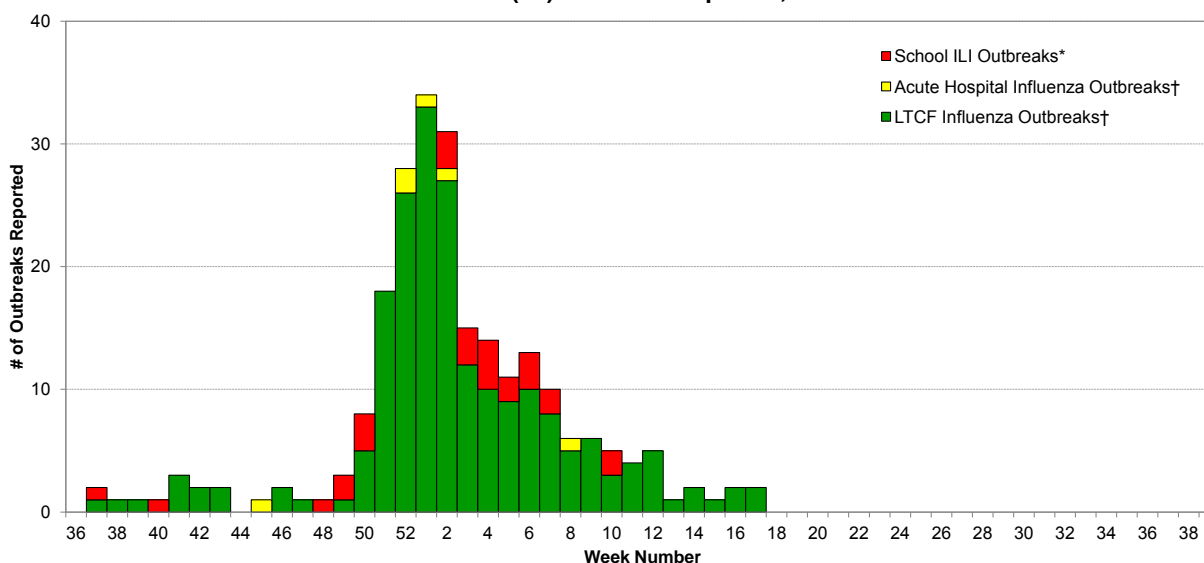
During the 2016-17 season (cumulatively since week 37, starting September 11, 2016), a total of 210 influenza outbreaks were reported including 200 in LTCFs, 6 in acute care settings, and 4 from other facility types. The majority (184/210, 88%) of facility outbreaks reported this season had influenza A detected [all A(H3N2) where subtype information is available]; however, an increasing number of outbreaks with influenza B detected were reported near the end of the season. In total, 25 influenza B outbreaks were reported. One outbreak with both influenza A and B detected was additionally reported.

The cumulative tally of LTCF outbreaks for the 2016-17 season (n=200) exceeds the total number of LTCF outbreaks reported during the last A(H3N2)-dominant season in 2014-15 (n=165 from week 40 to week 17), which had previously been associated with the highest number of LTCF outbreaks recorded in the past decade.

A total of 27 school ILI outbreaks, without etiologic agent identified, have also been reported so far during the 2016-17 season.

Since our last bulletin two weeks ago, 4 new influenza B outbreaks were reported from long-term care facilities (LTCFs); two had onset in week 16 (one in FHA and one in VCHA) and two had onset in week 17 (one in FHA and one in VIHA).

Number of influenza-like illness (ILI) outbreaks reported, British Columbia 2016-17



* School-based ILI outbreak defined as >10% absenteeism on any day, most likely due to ILI.

† Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one laboratory-confirmed case of influenza.

National

FluWatch (week 16, April 16 to 22, 2017)

Overall, influenza activity continues to decline slowly in Canada. In week 16, influenza B activity continued to exceed influenza A activity, with 50% or more of influenza laboratory detections, hospitalizations and outbreaks associated with influenza B. In keeping with the predominant circulation of A(H3N2) this season, the majority of laboratory detections, hospitalizations and deaths have been among adults ≥65 years old. 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, 2016 to May 4, 2017, the National Microbiology Laboratory (NML) received 1761 influenza viruses [1493 A(H3N2), 36 A(H1N1)pdm09 and 232 B] from Canadian laboratories for antigenic characterization.

Influenza A(H3N2): Of the 1493 influenza A(H3N2) viruses, only 351 (24%) had sufficient haemagglutination titre for antigenic characterization by haemagglutination inhibition (HI) assay. Of the 351 viruses characterized by HI assay, all were considered antigenically similar to A/Hong Kong/4801/2014, the WHO-recommended A(H3N2) component for the 2016-17 northern hemisphere influenza vaccine. Of the 351 viruses that were antigenically characterized with available sequencing information, 288 (82%) belonged to genetic group 3C.2a and 63 (18%) belonged to genetic group 3C.3a. Genetic characterization was performed to infer antigenic properties on the remaining 1142 viruses that did not grow to sufficient haemagglutination titre for HI assay. Of the 1142 viruses genetically characterized, all were reported to belong to genetic group 3C.2a, which includes the A/Hong Kong/4801/2014 vaccine strain.

Influenza A(H1N1)pdm09: All of the 36 A(H1N1)pdm09 viruses characterized were antigenically similar to A/California/7/2009, the WHO-recommended influenza A(H1N1) component for the 2016-17 northern hemisphere influenza vaccine.

Influenza B: Of the 232 influenza B viruses characterized, 54 (23%) were antigenically similar to a B/Brisbane/60/2008(Victoria lineage)-like virus, the WHO-recommended influenza B component for the 2016-17 northern hemisphere trivalent influenza vaccine. The remaining 178 (77%) viruses were characterized as a B/Phuket/3073/2013(Yamagata lineage)-like virus, the other WHO-recommended influenza B component for the 2016-17 northern hemisphere quadrivalent influenza vaccine containing two influenza B components.

National Microbiology Laboratory (NML): Antiviral Resistance

From September 1, 2016 to May 4, 2017, the NML received influenza viruses from Canadian laboratories for drug susceptibility testing.

Amantadine: Of the 219 influenza A viruses [190 A(H3N2) and 29 A(H1N1)pdm09] tested against amantadine, all were resistant.

Oseltamivir: Of the 988 influenza viruses [729 A(H3N2), 35 A(H1N1)pdm09 and 224 B] tested against oseltamivir, 986 out of 988 were sensitive; two A(H3N2) viruses were resistant to oseltamivir.

Zanamivir: Of the 987 influenza viruses [728 A(H3N2), 34 A(H1N1)pdm09 and 225 B] tested against zanamivir, all were sensitive.

Mid-season Estimates of 2016-17 Influenza Vaccine Effectiveness, North America

Canada

On February 9, 2017, researchers from the Canadian Sentinel Practitioner Surveillance Network (SPSN) published the first mid-season estimates of influenza vaccine effectiveness (VE) for the 2016-17 season. They found VE of 42% (95% confidence interval (CI): 18-59%) against outpatient medically attended, laboratory-confirmed A(H3N2) illness, which has been the dominant subtype so far this season. This finding indicates that, compared to unvaccinated people, the risk of A(H3N2) illness in vaccinated people was reduced by about 40%. This VE estimate is consistent with vaccine protection typically expected for A(H3N2)-dominant seasons, but is considerably higher than in the last A(H3N2)-dominant 2014-15 season when no vaccine protection was found.

The full report is available at: www.eurosurveillance.org/ViewArticle.aspx?ArticleId=22714.

United States

On February 17, 2017, the U.S. Flu VE Network published mid-season estimates of 2016-17 influenza VE, reporting an adjusted VE of 43% (95% CI: 29-54%) for A(H3N2). These findings are consistent with Canadian mid-season estimates published last week, suggesting VE of around 40% against outpatient, medically attended A(H3N2) illness, which has been the dominant influenza strain so far during the 2016-17 season. Both the Canadian and U.S. studies used a test-negative design to derive influenza VE.

For details see: www.cdc.gov/mmwr/volumes/66/wr/mm6606a3.htm?s_cid=mm6606a3_w.

International

USA (week 16, April 16 to 22, 2017)

During week 16, influenza activity decreased in the United States. The most frequently identified influenza virus type reported by public health laboratories during week 16 was influenza B. The percentage of respiratory specimens testing positive for influenza in clinical laboratories decreased. Of the 1089 A(H3N2) viruses genetically characterized by the US CDC during the 2016-17 season, 95% belonged to genetic group 3C.2a, including the newly emerging subgroup 3C.2a1, and 5% to group 3C.3a based on analysis of HA gene segments. The proportion of deaths attributed to pneumonia and influenza (P&I) was below the system-specific epidemic threshold. Six influenza-associated pediatric deaths were reported. A cumulative rate for the season of 62.7 laboratory-confirmed influenza-associated hospitalizations per 100,000 population was reported. The proportion of outpatient visits for ILI was 1.8%, which is below the national baseline of 2.2%. The geographic spread of influenza in seven states was reported as widespread; Guam, Puerto Rico and 11 states reported regional activity; the District of Columbia and 19 states reported local activity; 13 states reported sporadic activity; and the U.S. Virgin Islands reported no activity. Details are available at: www.cdc.gov/flu/weekly/.

WHO (May 1, 2017)

Influenza activity in the temperate zone of the northern hemisphere continued to decrease. Influenza activity remained low in the temperate zone of the southern hemisphere. Worldwide, influenza A(H3N2) and B viruses were predominant, with an increased proportion of influenza B viruses detected in recent weeks.

- In North America, overall influenza activity continued to decrease. In Canada, influenza A(H3N2) viruses continued to be the most common subtype of influenza detected, followed by influenza B virus; in Mexico, all seasonal influenza types/subtypes were detected; in the United States influenza B virus was predominant.
- In Europe, influenza activity continued to decrease to low levels, with detections of predominantly influenza B viruses in Northern and Eastern Europe. ILI and severe acute respiratory infection (SARI) indicators were generally low or below baseline in most countries.
- In Northern Africa, influenza activity remained low. Sporadic detections of influenza A(H3N2) viruses were reported in Tunisia.
- In Western Asia, influenza activity continued to decrease with influenza B viruses predominant in the region. SARI levels continued to decrease in Georgia, while remained stable in Armenia. In Oman, low influenza activity was reported with influenza A(H1N1)pdm09 virus predominant.
- In Central Asia, ILI and SARI activities continued to decrease; influenza virus detections were also low.
- In East Asia, influenza activity continued to be reported with all seasonal influenza types/subtypes detected in the region. In both Northern and Southern China, influenza A(H1N1)pdm09 virus detections increased in recent weeks. Influenza B virus detections continued to be reported in Southern China and the Republic of Korea; influenza B Victoria lineage was predominant in Southern China.
- In the Caribbean and Central America countries, respiratory virus activity remained low.
- In tropical South America, influenza activity increased slightly with influenza A(H3N2) viruses predominating. Other respiratory virus activities remained low in general, except in Colombia where elevated activity of RSV continued to be reported.
- In Western Africa, low levels of influenza activity continued to be reported in Côte d'Ivoire, Ghana, Senegal and Sierra Leone, with all seasonal influenza types/subtypes co-circulating in the region. In Eastern Africa, increased detections of influenza A(H3N2) and B viruses were reported in Madagascar and Tanzania in the recent weeks.
- In Southern Asia, influenza activity continued to be reported although it appeared to be decreasing. In India and the Maldives, influenza A(H1N1)pdm09 continued to be reported. In Pakistan, sporadic cases of influenza A(H3N2) viruses were reported in the recent weeks. In Bhutan, ILI levels and influenza activity appeared to decrease, with influenza A(H3N2) and B viruses circulating.
- In South East Asia, influenza activity remained low, with all seasonal influenza types/subtypes detected in the region.
- In the temperate zone of the Southern Hemisphere, influenza activity was at inter-seasonal levels. In Chile, ILI activity increased but has not reached the seasonal threshold in recent weeks, consistent with past seasonal trends.
- From April 3 to 16, 2017, the WHO GISRS laboratories tested more than 109,373 specimens during that time period. 14,597 were positive for influenza viruses, of which 6108 (42%) were typed as influenza A and 8489 (58%) as influenza B. Of the subtyped influenza A viruses, 1358 (43%) were influenza A(H1N1)pdm09 and 1834 (58%) were influenza A(H3N2). Of the characterized B viruses, 747 (49%) belonged to the B/Yamagata lineage and 767 (51%) to the B/Victoria lineage.

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

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 (Victoria-lineage)-like 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 (Yamagata-lineage)-like 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 2017-18 Northern Hemisphere Influenza Vaccine

On March 2, 2017, the WHO announced the recommended strain components for the 2017-18 northern hemisphere trivalent influenza vaccine (TIV):*

- an A/Michigan/45/2015 (H1N1)pdm09-like virus;†
- an A/Hong Kong/4801/2014 (H3N2)-like virus;
- a B/Brisbane/60/2008 (Victoria-lineage)-like 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 (Yamagata-lineage)-like virus.

* These recommended strains are the same as those recommended for the 2017 southern hemisphere TIV and represent a change for one of the three components used for the 2016-17 northern hemisphere TIV and 2016 southern hemisphere TIV.

† Recommended strain represents a change from an A/California/7/2009-like virus, which had been retained as the A(H1N1)pdm09 component since the 2009 pandemic, to an A/Michigan/45/2015-like virus belonging to the emerging phylogenetic subclade 6B.1.

For further details: www.who.int/influenza/vaccines/virus/recommendations/2017_18_north/en/.

Additional Information

Explanatory Note:

The surveillance period for the 2016-17 influenza season is defined starting in week 40. Weeks 36-39 of the 2015-16 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/?ID=122&Language=ENG

Web Sites:

BCCDC Emerging Respiratory Pathogen Updates:

www.bccdc.ca/health-professionals/data-reports/emerging-respiratory-virus-updates

Influenza Web Sites

Canada – Influenza surveillance (FluWatch): healthycanadians.gc.ca/diseases-conditions-maladies-affectations/disease-maladie/flu-grippe/surveillance/index-eng.php

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/

Joint ECDC – WHO/Europe weekly influenza update (Flu News Europe): flunewseurope.org

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

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	<u>Reporting Information</u> Health unit/medical health officer notified? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Person Reporting: _____ Title: _____
	Contact Phone: _____ Email: _____
	Health Authority: _____ HSDA: _____
	Full Facility Name: _____
	Is this report: <input type="checkbox"/> First Notification (<i>complete section B below; Section D if available</i>) <input type="checkbox"/> Update (<i>complete section C below; Section D if available</i>) <input type="checkbox"/> Outbreak Over (<i>complete section C below; Section D if available</i>)

B	<u>First Notification</u>														
	Type of facility: <input type="checkbox"/> LTCF <input type="checkbox"/> Acute Care Hospital <input type="checkbox"/> Senior's Residence <i>(if ward or wing, please specify name/number: _____)</i> <input type="checkbox"/> Workplace <input type="checkbox"/> School (grades: _____) <input type="checkbox"/> Other (_____)														
	Date of onset of first case of ILI (dd/mm/yyyy): <u>DD / MMM / YYYY</u>														
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Numbers to date</th> <th style="width: 50%;">Residents/Students</th> <th style="width: 25%;">Staff</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td></td> <td></td> </tr> <tr> <td>With ILI</td> <td></td> <td></td> </tr> <tr> <td>Hospitalized</td> <td></td> <td></td> </tr> <tr> <td>Died</td> <td></td> <td></td> </tr> </tbody> </table>	Numbers to date	Residents/Students	Staff	Total			With ILI			Hospitalized			Died	
Numbers to date	Residents/Students	Staff													
Total															
With ILI															
Hospitalized															
Died															

C	<u>Update AND Outbreak Declared Over</u>														
	Date of onset for most recent case of ILI (dd/mm/yyyy): <u>DD / MMM / YYYY</u>														
	If over, date outbreak declared over (dd/mm/yyyy): <u>DD / MMM / YYYY</u>														
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Total															
With ILI															
Hospitalized															
Died															

D	<u>Laboratory Information</u>
	Specimen(s) submitted? <input type="checkbox"/> Yes (location: _____) <input type="checkbox"/> No <input type="checkbox"/> Don't know If yes, organism identified? <input type="checkbox"/> Yes (specify: _____) <input type="checkbox"/> No <input type="checkbox"/> Don't know