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

British Columbia Influenza Surveillance Bulletin

Influenza Season 2014-15, Number 20, Weeks 11-12
March 15 to 28, 2015

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Influenza B Continues to Circulate at Low Levels in BC

In weeks 11-12 (March 15 to 28, 2015), influenza B continued to be the predominant influenza virus circulating in BC, albeit at low levels. Other surveillance indicators remained at expected seasonal levels.

At the BC provincial laboratory, overall influenza positivity remained elevated but decreased slightly from 17% in week 11 to 15% in week 12. Influenza B comprised more than two-thirds of influenza detections during this period. However, influenza A(H3N2) and respiratory syncytial virus continued to co-circulate, also at low levels.

Since our last bulletin issued 2 weeks ago, 4 new influenza outbreaks were reported from long-term care facilities, including 2 due to influenza A and 2 due to influenza B. The total number of facility outbreaks this season (n=172) now exceeds by almost 90% the prior full season record of dominant, mismatched A(H3N2) in 2012-13 (n=91).

Prepared by BCCDC Influenza & Emerging Respiratory Pathogens Team
Contributors: Helen Guiyun Li, Catharine Chambers, Lisan Kwindt, Danuta Skowronski

Report Disseminated: April 2, 2015

Provincial Health Services Authority
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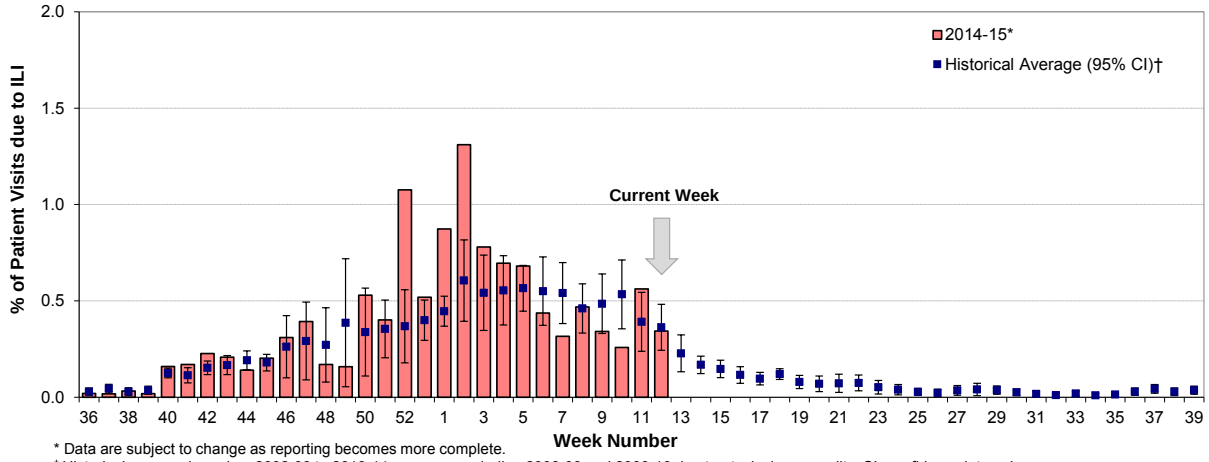
A research and teaching centre affiliated with UBC

British Columbia

Sentinel Physicians

The proportion of patients with influenza-like illness (ILI) among those presenting to sentinel physicians remained at or above historical averages for this time of year in weeks 11-12. Rates were 0.6% in week 11 and 0.3% in week 12. So far, 66% and 57% of sentinel sites have reported data for weeks 11 and 12, respectively.

Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2014-15

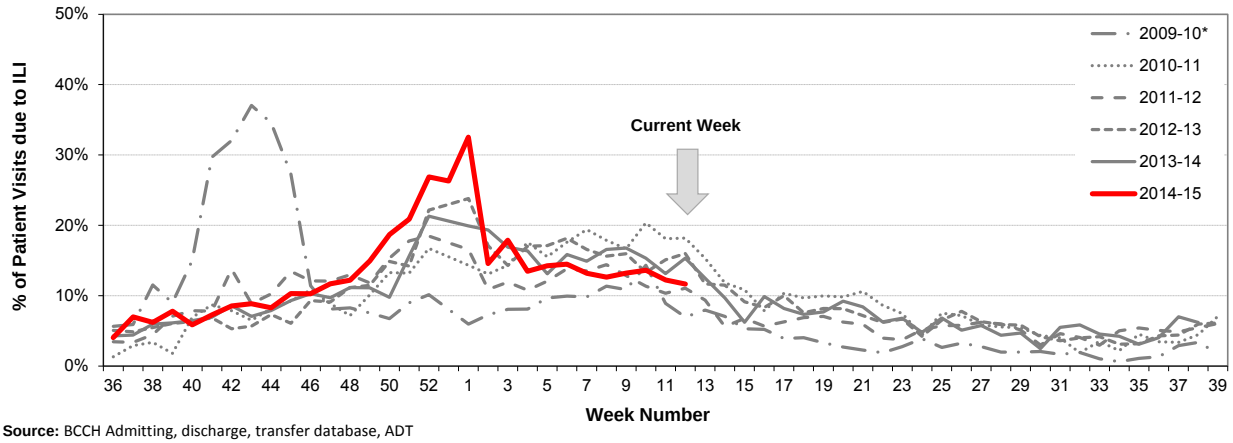


* Data are subject to change as reporting becomes more complete.
† Historical average based on 2002-03 to 2013-14 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

BC Children's Hospital Emergency Room

The proportion of visits to BC Children's Hospital Emergency Room (ER) attributed to ILI remained stable at around 12% in weeks 11-12, consistent with rates observed in previous seasons for this time of year.

Percent of patients presenting to BC Children's Hospital ER with triage chief complaint of "flu," "influenza" or "fever/cough," British Columbia, 2014-15

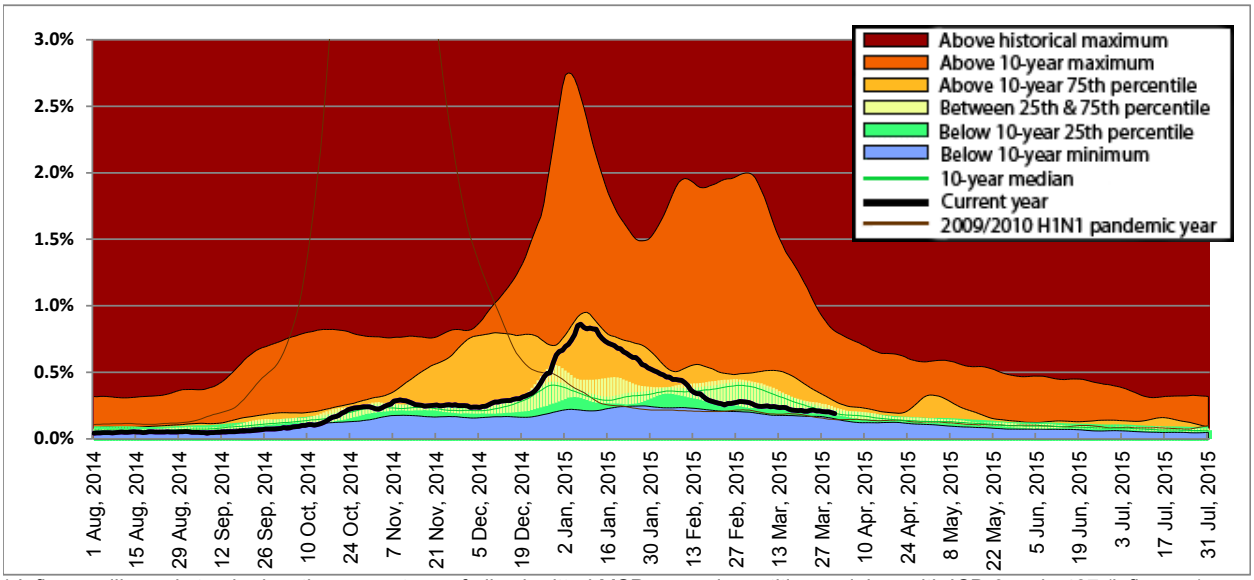


Source: BCCH Admitting, discharge, transfer database, ADT
* Data from 2010-11 to 2014-15 are based on new variable (Triage Chief Complaint) for capturing ILI symptoms and are not directly comparable to data for 2009-10. In week 9 of the 2011-12 season, the BCCH ER implemented a new data collection system, the National Ambulatory Care Reporting System (NACRS); data are not directly comparable to data collected using old system.

Medical Services Plan

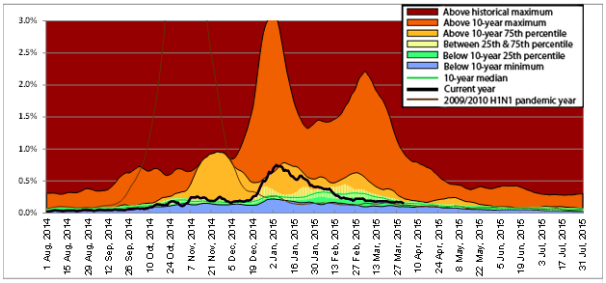
In weeks 11-12, BC Medical Services Plan (MSP) general practitioner claims for influenza illness (II), as a proportion of all submitted MSP claims, remained stable within or below expected historical ranges for the province overall and in all regional Health Authorities with the exception of NHA where the rates were above the 10-year 75th percentile in week 12.

Service claims submitted to MSP for influenza illness (II)* as a proportion of all submitted general practitioner service claims, British Columbia, 2014-15

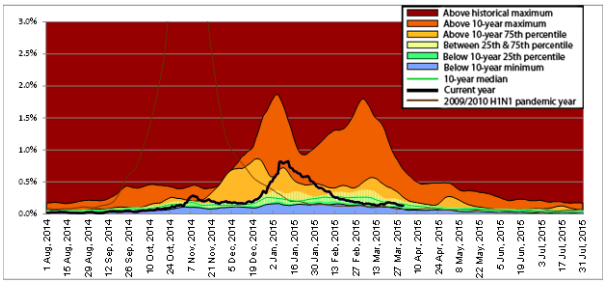


* Influenza illness is tracked as the percentage of all submitted MSP general practitioner claims with ICD-9 code 487 (influenza).
Data provided by Population Health Surveillance and Epidemiology, BC Ministry of Health Services.
Note: MSP week beginning 3 August 2014 corresponds to Sentinel ILI week 32; data current to March 31, 2015.

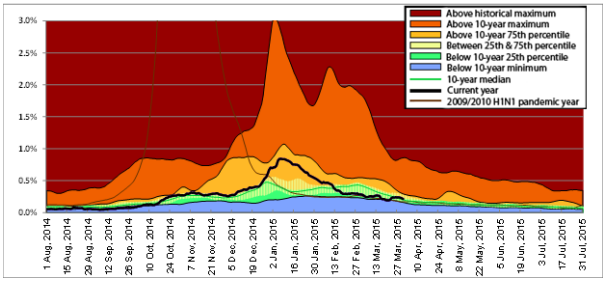
Interior



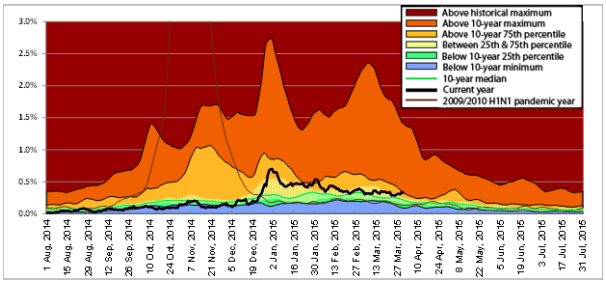
Vancouver Island



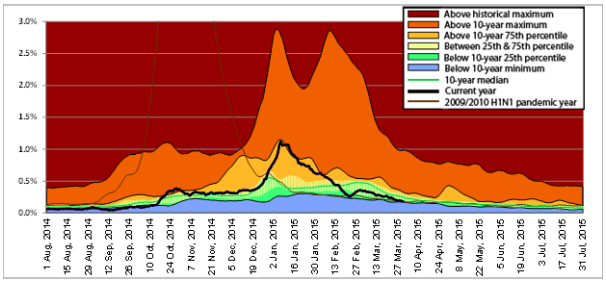
Fraser



Northern



Vancouver Coastal



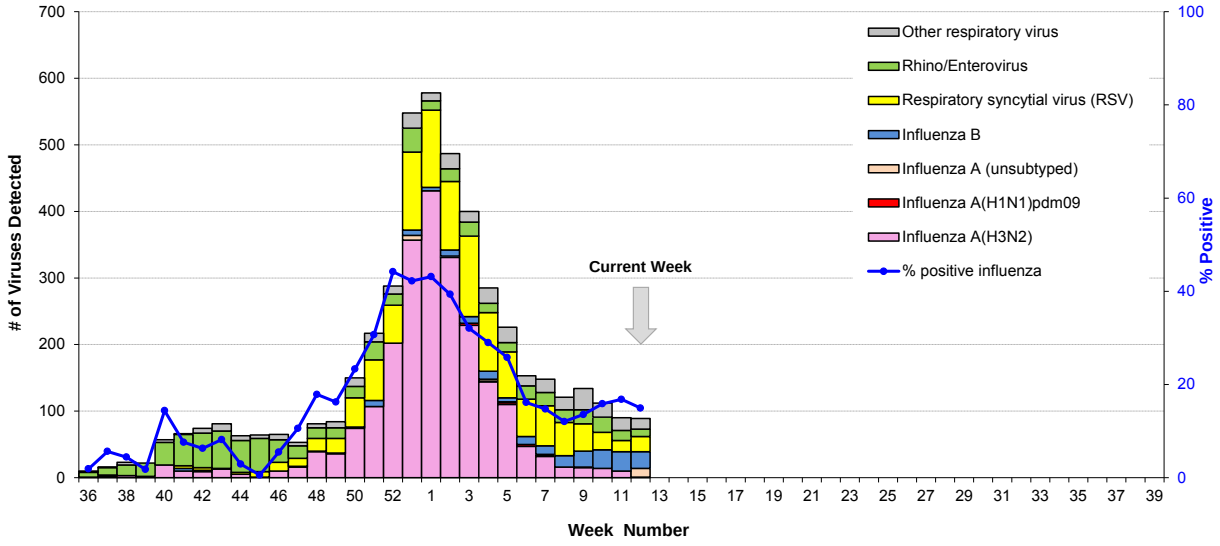
Laboratory Reports

BC Public Health Microbiology & Reference Laboratory (PHMRL)

In weeks 11-12, the BC Public Health Microbiology & Reference Laboratory (PHMRL) tested 489 patients for respiratory viruses. Of these, 78 (16%) tested positive for influenza, including 24 (31%) influenza A [11 A(H3N2) and 13 with subtype pending] and 54 (69%) influenza B. Influenza positivity decreased slightly from 17% in week 11 to 15% in week 12, following a gradual increase from 12% in week 8 to 17% in week 11, driven by low-level influenza B activity. In weeks 11 and 12, 13% and 10% of patients were positive for influenza B, respectively, compared to ≤5% for influenza A. Influenza B comprised more than two-thirds of influenza detections during this period. Respiratory syncytial virus (RSV) activity continued to decline during this period; RSV positivity was 7-9% weeks 11-12.

Cumulatively, during the 2014-15 influenza season (since week 40, starting September 28, 2014), 2,507 (28%) patients have tested positive for influenza at the BC PHMRL, including 2,293 (91%) with influenza A [2,257 A(H3N2), 14 A(H1N1)pdm09, 2 A(H7N9), and 20 subtype pending], 213 (9%) with influenza B, and one elderly adult patient who had influenza A(H3N2) and influenza B infections detected at different times during the 2014-15 season.

Influenza and other virus detections among respiratory specimens submitted to BC Public Health Microbiology & Reference Laboratory, PHSA, 2014-15

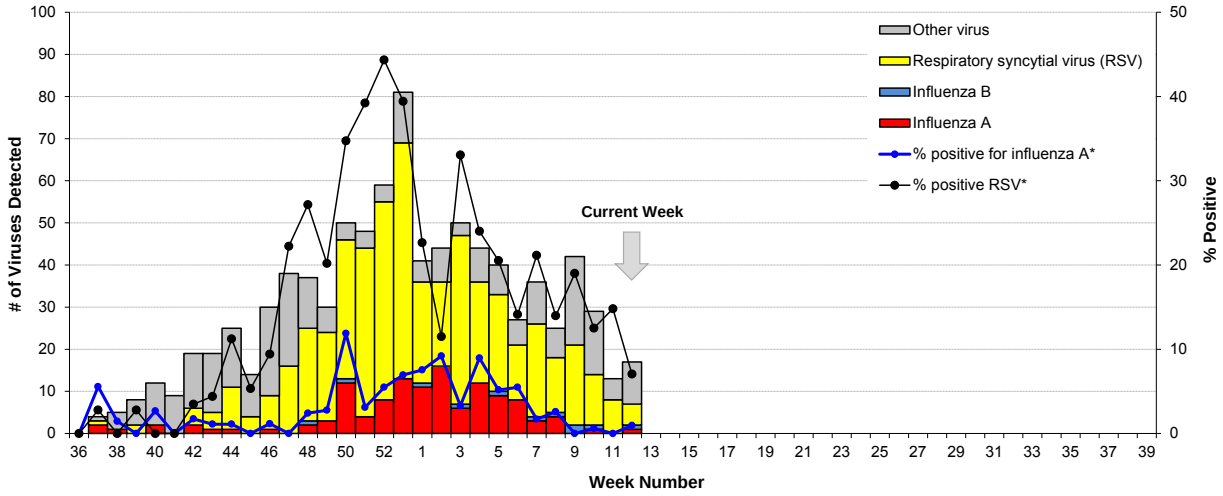


Note: Data current to April 1, 2015.

BC Children's and Women's Health Centre Laboratory

In weeks 11-12, the BC Children's and Women's Health Centre Laboratory conducted 197 tests for influenza A and 125 tests for influenza B. Of these, one (0.5%) was positive for influenza A and 1 (0.8%) was positive for influenza B, both in week 12. RSV continued to be the most commonly detected respiratory virus during this period, although RSV detections have declined substantially following peak seasonal activity in week 52.

Influenza and other virus detections among respiratory specimens submitted to BC Children's and Women's Health Centre Laboratory, 2014-15



* Positive rates were caculated 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.

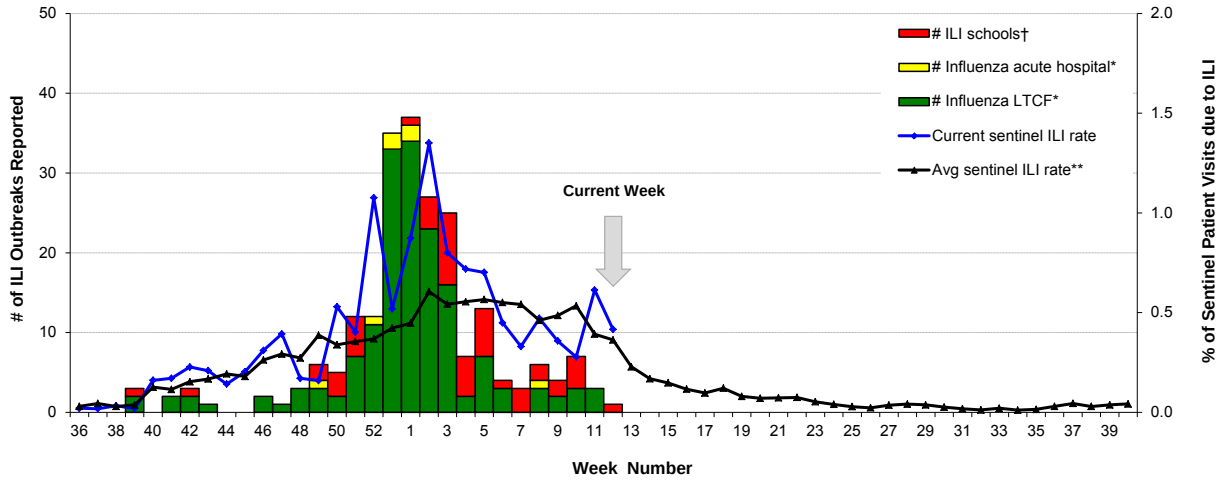
Influenza-like Illness (ILI) Outbreaks

Since our last bulletin issued 2 weeks ago, 4 new laboratory-confirmed influenza outbreaks were reported in long-term care facilities (LTCFs), including 2 due to influenza A (subtype pending) and 2 due to influenza B. Of the influenza A outbreaks, one had symptom onset in week 10 in VCHA and one in week 11 in VIHA. Both influenza B outbreaks had onset in week 11 in FHA. One new laboratory-confirmed influenza B outbreak in a school was also reported from NHA in week 12.

Cumulatively, since week 39 (starting September 21, 2014), 172 facility outbreaks due to laboratory-confirmed influenza have been reported, including 165 from LTCFs and 7 from acute care. All but 11 of these outbreaks were due to influenza A [all A(H3N2) where subtype information is available]; 11 were due to influenza B (6 of which had onset in weeks 8-11) or both influenza A and B. A total of 8 school outbreaks due to laboratory-confirmed influenza have also been reported so far this season, including 6 due to influenza A and 2 due to influenza B.

The number of year-to-date facility outbreaks reported during the 2014-15 season is double the same period (week 40 – week 12) during the last 2012-13 season of dominant, mismatched H3N2 activity (n=86), and has surpassed by almost 90% the total number of facility influenza outbreaks reported across the entire 2012-13 season (week 40 – week 17) (n=91), which had previously been the year of record facility outbreak reports, now supplanted by the 2014-15 season.

Number of influenza-like illness (ILI) outbreaks reported, compared to current sentinel ILI rate and historical average sentinel ILI rate, British Columbia, 2014-15



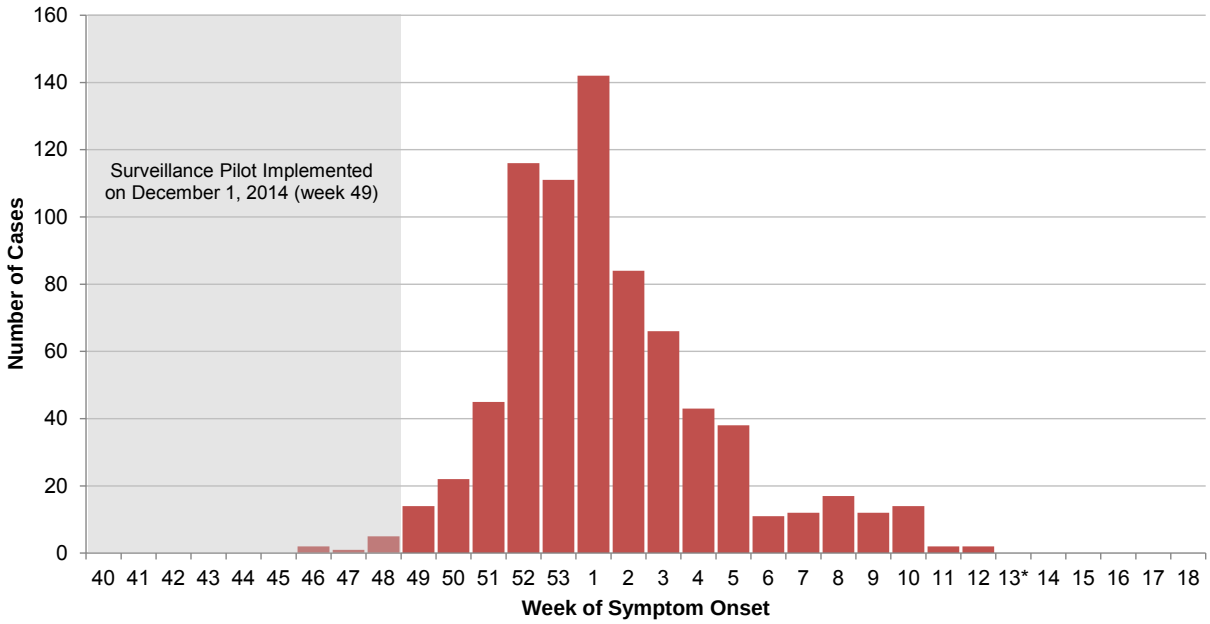
* Facility-based influenza outbreaks defined as 2 or more ILI cases within 7-day period, with at least one **laboratory-confirmed** case of influenza.
† School-based ILI outbreak defined as >10% absenteeism on any day, most likely due to ILI.
** Historical values exclude 2008-09 and 2009-10 seasons due to atypical seasonality.

Laboratory-confirmed Influenza Hospitalizations

On December 1, 2014, the BC Centre for Disease Control and the regional Health Authorities implemented an influenza severe outcome surveillance (SOS) pilot in BC for monitoring laboratory-confirmed influenza hospitalizations. An epidemic curve of hospitalized influenza cases by week of symptom onset is shown below, mirroring trends observed in other surveillance indicators. Of note, reporting delays should be taken into account in interpreting trends, particularly for the most recent weeks of the epidemic curve displayed.

The vast majority of severe influenza cases this season have been due to influenza A, predominately A(H3N2) where subtype information is available; however, an increasing proportion of cases in recent weeks are due to influenza B, consistent with provincial surveillance indicators showing low-level, late season influenza B activity. Elderly adults are disproportionately represented among influenza-related hospitalizations this season, as is typically observed during A(H3N2)-dominant seasons, with a median age of 79 years overall (range: <1 year to >100 years). The majority of cases (>80%) have had one or more pre-existing chronic comorbidity.

Number of laboratory-confirmed influenza hospitalizations by week of symptom onset, British Columbia, 2014-15



* Based on partial week; data are subject to change as reporting becomes more complete. Includes influenza SOS case report forms received as of 12:00 PM PST on April 2, 2015.

Symptom onset date was imputed as hospital admission date minus two days where symptom onset was unknown.

Only severe cases of laboratory-confirmed influenza admitted to an intensive care unit (ICU) are reported in FHA; in all other Health Authorities, both hospitalizations and ICU admissions are reported.

National

FluWatch (week 11)

In week 11, the majority of influenza activity is occurring in the Central and Atlantic provinces. Influenza B detections continue to increase steadily across Canada, while detections of influenza A continue to steadily decrease. This increase in influenza B is expected as influenza B often shows up later in the influenza season. Despite the late-season circulation of influenza B, influenza A(H3N2) remains the most common influenza virus detected this season to date and seniors continue to be affected. In week 11, 958 (5%) influenza viruses were detected, including 310 (32%) influenza A [71 A(H3N2), 3 A(H1N1)pdm09, and 236 unsubtyped] and 648 (68%) influenza B. Details are available at: www.phac-aspc.gc.ca/fluwatch/14-15/index-eng.php.

National Microbiology Laboratory (NML): Strain Characterization

From September 1, 2014 to April 2, 2015, the NML has antigenically characterized 490 influenza viruses [176 A(H3N2), 9 A(H1N1)pdm09, and 305 influenza B] and genetically characterized 1,025 influenza A(H3N2) viruses that were received from Canadian laboratories.

Influenza A(H3N2): Of the 1,201 A(H3N2) viruses characterized so far this season by the NML, 1,198 (~100%) showed antigenic or genetic evidence of antigenic drift (i.e. vaccine mismatch). Of the 176 A(H3N2) viruses antigenically characterized by haemagglutinin inhibition (HI) assay: 170 (97%) were similar to A/Switzerland/9715293/2013, the WHO-recommended A(H3N2) component for the 2015-16 Northern Hemisphere influenza vaccine; one (1%) was similar to A/Texas/50/2012, the WHO-recommended A(H3N2) component for the 2014-15 Northern Hemisphere influenza vaccine used this season; and 5 (3%) showed reduced titres to A/Texas/50/2012 but could not be further characterized in relation to A/Switzerland/9715293/2013 due to insufficient titres. Genetic characterization was performed on 1,025 A(H3N2) viruses that did not grow to sufficient titres for antigenic characterization by HI assay. Of the 1,025 A(H3N2) viruses genetically characterized, 1,023 (~100%) belonged to a genetic group that typically shows reduced titres to A/Texas/50/2012 due to amino acid mutations at antigenic sites. The remaining two (<1%) viruses belonged to a genetic group that does not show reduced titres to A/Texas/50/2012.

Influenza A(H1N1)pdm09: Of the 9 A(H1N1)pdm09 viruses characterized, all were antigenically similar to A/California/7/2009, the WHO-recommended A(H1N1)pdm09 component for the 2014-15 Northern Hemisphere influenza vaccine.

Influenza B: Of the 305 influenza B viruses characterized, 288 (94%) viruses were antigenically similar to B/Massachusetts/2/2012 (Yamagata-lineage), the WHO-recommended influenza B vaccine component for the 2014-15 Northern Hemisphere influenza vaccine; 3 (1%) viruses showed reduced titres with antiserum produced against B/Massachusetts/2/2012, signalling antigenic drift from the vaccine strain; and 14 (5%) were antigenically similar to B/Brisbane/60/2008 (Victoria-lineage), the WHO-recommended influenza B/Victoria vaccine component for the quadrivalent 2014-15 Northern Hemisphere influenza vaccine.

National Microbiology Laboratory (NML): Antiviral Resistance

From September 1, 2014 to April 2, 2015, the NML received influenza viruses from Canadian laboratories for drug susceptibility testing. Of the 1,236 influenza A viruses [1,230 A(H3N2) and 6 A(H1N1)pdm09] tested against amantadine, all but one were resistant; one A(H3N2) virus was sensitive to amantadine. Of the 1,094 influenza viruses [831 A(H3N2), 6 A(H1N1)pdm09, and 257 B] tested against oseltamivir, all but one were sensitive; one A(H3N2) virus was resistant to oseltamivir. Of the 1,090 influenza viruses [827 A(H3N2), 6 A(H1N1)pdm09, and 257 B] tested against zanamivir, all were sensitive.

Interim Estimates of 2014/15 Influenza Vaccine Effectiveness, Canada

Canadian Sentinel Physician Surveillance Network (SPSN), Community-based

On January 29, the Canadian Sentinel Physician Surveillance Network (SPSN) published interim estimates of vaccine effectiveness (VE) against medically attended, laboratory-confirmed influenza infection for the 2014/15 influenza vaccine. Of the characterized viruses contributing to VE analysis, virtually all (99%) clustered with phylogenetic clades that are considered antigenically distinct from the vaccine strain. Consistent with this substantial vaccine mismatch in circulating viruses, little to no protection against the dominant circulating A(H3N2) viruses was found by the Canadian SPSN. VE against medically attended laboratory-confirmed A(H3N2) infection was estimated at -8%, with 95% confidence intervals (CIs) spanning -50% to 23%. When analyses were restricted to non-elderly adults 20-64 years old, VE was 2% (95% CI: -49 to 36%). Details are available at: www.eurosurveillance.org/ViewArticle.aspx?ArticleId=21022.

Canadian Immunization Research Network (CIRN), Hospital-based

On February 5, the Serious Outcomes Surveillance Network of the Canadian Immunization Research Network (CIRN) published interim estimates of VE against influenza-associated hospitalizations for laboratory-confirmed influenza for the 2014/15 influenza vaccine. Influenza A(H3N2) was the predominant influenza virus detected among hospitalized cases, accounting for 99% of influenza A viruses with known subtype. Unmatched VE estimates adjusted for age and comorbidity were -17% (95% CI: -56 to 13%) overall and -22% (95% CI: -77 to 16%) for influenza A(H3N2). Among elderly adults ≥65 years old, adjusted VE estimates were -25% (95% CI: -74 to 10%) and -33 (95% CI: -104 to 13%), respectively. Among non-elderly adults <65 years old, VE estimates were 11% (95% CI: -66 to 52%) and 8% (95% CI: -102 to 58%), respectively. Details are available at: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=21024.

Final End-of-season Estimates of 2013/14 Influenza Vaccine Effectiveness, Canada

Canadian Sentinel Physician Surveillance Network (SPSN)

On March 17, the Canadian Sentinel Physician Surveillance Network (SPSN) published final end-of-season estimates of vaccine effectiveness (VE) against medically attended, laboratory-confirmed influenza infection for the 2013/14 influenza vaccine. The 2013/14 influenza season in Canada was characterized by resurgent and dominant A(H1N1)pdm09 activity, followed by a late-season influenza B/Yamagata wave. Adjusted VE against antigenically well-conserved influenza A(H1N1)pdm09 viruses was 71% (95% CI: 58 to 80%). Two phylogenetic clades of influenza B/Yamagata viruses were detected: 83% clustered with the prior 2012-13 season's B/Wisconsin/01/2010-like (clade 3) vaccine strain, while 17% clustered with the current 2013-14 season's B/Massachusetts/02/2012-like (clade 2) vaccine strain. Adjusted VE against influenza B/Yamagata overall was 73% (95% CI: 56 to 83%), with lower VE found against clade-level mismatched B/Wisconsin/01/2010-like (clade 3) viruses. Details are available at: http://jid.oxfordjournals.org/content/early/2015/03/17/infdis.jiv177.abstract.

International

USA (week 11)

During week 11, influenza activity continued to decrease, but remained elevated in the United States. Of the 12,824 specimens tested, 1,358 (11%) were positive for influenza, including 334 (25%) influenza A [101 A(H3N2), 1 A(H1N1)pdm09, and 232 with subtyping not performed] and 1,024 (75%) influenza B. Of the 1,026 A(H3N2) influenza viruses collected since October 1, 2014, and characterized by HI assay, 242 (24%) were characterized as A/Texas/50/2012-like, the A(H3N2) component of the 2014-15 Northern Hemisphere influenza vaccine, and 784 (76%) either showed reduced titres with antiserum produced against A/Texas/50/2012 or belonged to a genetic group that typically shows reduced titres to A/Texas/50/2012. Among viruses that showed reduced titres with antiserum raised against A/Texas/50/2012, most were antigenically similar to A/Switzerland/9715293/2013, the A(H3N2) virus selected for the 2015-16 Northern Hemisphere influenza vaccine. The proportion of outpatient visits for ILI was 2.2%, above the national baseline of 2.0%, and the proportion of deaths attributed to pneumonia and influenza was above the epidemic threshold. Nine influenza-associated paediatric deaths were reported. Details are available at: www.cdc.gov/flu/weekly/.

WHO (as of March 23, 2015)

Globally, influenza activity remained elevated in the Northern Hemisphere with influenza A(H3N2) viruses predominating, although some countries in Asia, Europe and North Africa reported high levels of activity associated with influenza A(H1N1)pdm09 viruses. In North America, influenza activity was decreasing but remained above the epidemic threshold. Influenza A(H3N2) viruses predominated so far this season. In Europe, influenza activity appeared to have peaked in many countries; influenza A(H3N2) virus continued to be predominant. In northern Africa and the Middle East, influenza activity continued to decrease with influenza A(H1N1)pdm09 viruses predominating, except in Egypt, where there was co-circulation with influenza A(H3N2) and influenza B viruses. In the temperate countries of eastern Asia, influenza A(H3N2) was predominant with very little influenza A(H1N1)pdm09 virus activity, while in western Asia, influenza A(H1N1)pdm09 and influenza B were predominant. In tropical countries of the Americas, influenza activity remained low with mainly A(H3N2) viruses detected. In tropical Asia, influenza activity patterns varied with influenza A(H1N1)pdm09 predominant in Bhutan and India, influenza A(H3N2) predominant in the Hong Kong Special Administrative Region, and influenza B predominant in south China. In the Southern Hemisphere, influenza activity continued at inter-seasonal levels. From February 22 to March 7, 2015, the WHO Global Influenza Surveillance and Response System (GISRS) laboratories tested more than 111,964 specimens. Of these, 27,176 were positive for influenza viruses: 17,711 (65%) were typed as influenza A and 9,464 (35%) as influenza B. Of the sub-typed influenza A viruses, 3,383 (34%) were influenza A(H1N1)pdm09 and 6,594 (66%) were influenza A(H3N2). Of the characterized B viruses, 1,903 (97%) belonged to the B-Yamagata lineage and 57 (3%) 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 2014-15 Northern Hemisphere Influenza Vaccine

On February 20, 2014, the WHO announced the recommended strain components for the 2014-15 Northern Hemisphere trivalent influenza vaccine (TIV):*

- an A/California/7/2009(H1N1)pdm09-like virus;
- an A/Texas/50/2012(H3N2)-like virus;
- a B/Massachusetts/2/2012-like (Yamagata-lineage) virus.

*These recommended strains are the same as those used for the 2013-14 Northern Hemisphere vaccine.

For further details: www.who.int/influenza/vaccines/virus/recommendations/2014_15_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.§

* These recommended strains are the same as those that will be 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

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/dis-cond/DiseaseStatsReports/EmergingRespiratoryVirusUpdates.htm

Influenza Web Sites

Canada – Flu Watch: www.phac-aspc.gc.ca/fluwatch/
Washington State Flu Updates: www.doh.wa.gov/Portals/1/Documents/5100/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/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

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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