






# OUTBREAK REPORT FORM

<b>Outbreak Summary</b>		<b>Outbreak No.</b> <input type="text"/>	
<b>Reporting Authority</b>			
<b>Officer responsible for investigation</b>	<input type="text"/>	<b>Date outbreak reported</b>	<input type="text"/> dd/mm/yyyy 
<input type="radio"/> Interim report <input type="radio"/> Final report - date finalised <input type="text"/> dd/mm/yyyy 		<input type="radio"/> Not an outbreak	
<b>Name of outbreak (optional)</b>	<input type="text"/>		
<b>Condition and Implicated Contaminant</b> 			
<b>Implicated contaminant (pathogen)</b>	<input type="text"/>	<input type="checkbox"/> Unknown	
<b>                                subtype</b>	<input type="text"/>		
<b>Condition (disease)</b>	<input type="text"/>	<b>Other, specify</b>	<input type="text"/>
<b>Other known condition/implicated pathogen</b>	<input type="radio"/> Yes <input type="radio"/> No		
<b>Implicated contaminant (pathogen)</b>	<input type="text"/>	<input type="checkbox"/> Unknown	
<b>                                subtype</b>	<input type="text"/>		
<b>Condition (disease)</b>	<input type="text"/>	<b>Other, specify</b>	<input type="text"/>
<b>CASE DEFINITION(S)</b>			
<b>Laboratory confirmed case</b>	<input type="text"/>		
<b>Clinically confirmed case</b>	<input type="text"/>		
<b>Probable case</b>	<input type="text"/>		
<b>Outbreak Demographics</b>			
<b>Number of people exposed</b>	<input type="text"/>	<input type="radio"/> Actual <input type="radio"/> Approx <input type="checkbox"/> Unknown	
<b>Number of cases(as per case defn above)</b>			
Lab confirmed	<input type="text"/>	Number Hospitalised	<input type="text"/>
Clinically confirmed	<input type="text"/>	Number Died	<input type="text"/>
Probable	<input type="text"/>		
<b>Total</b>	<input type="text"/>		
<b>Outbreak dates</b>	Onset of illness in first case	<input type="text"/> dd/mm/yyyy 	or <input type="checkbox"/> Outbreak ongoing
	Onset of illness in last case	<input type="text"/> dd/mm/yyyy 	
<b>Age of cases</b>	Number for which age recorded	<input type="text"/>	
	Median age (years)	<input type="text"/>	Range (years) <input type="text"/>
<b>Sex of cases</b>	Number of males	<input type="text"/>	Number of females <input type="text"/>
<b>Incubation period</b>	Median	<input type="text"/> days <input type="radio"/> hrs	Range <input type="text"/> days <input type="radio"/> hrs
<b>Duration of illness</b>	Median	<input type="text"/> days <input type="radio"/> hrs	Range <input type="text"/> days <input type="radio"/> hrs

Outbreak Summary		Outbreak No. <input style="width: 100px;" type="text"/>
<b>Circumstances of Exposure/Transmission</b>		
<b>How was the outbreak first recognised?</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="radio"/> Increase in disease incidence</div> <div style="width: 50%;"><input type="radio"/> Cases had person to person contact with other cases(s)</div> <div style="width: 50%;"><input type="radio"/> Cases attended common event</div> <div style="width: 50%;"><input type="radio"/> Common organism type/strain characteristics between cases</div> <div style="width: 50%;"><input type="radio"/> Cases linked to common source (eg food, water, environmental site)</div> <div style="width: 50%;"><input type="radio"/> Other means (specify) <input style="width: 150px;" type="text"/></div> </div>		
<b>Were these cases part of a well-defined exposed group</b> <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown</span> <b>(eg Common event, institutional, environmental, household)</b> If yes, date of exposure <input style="width: 100px;" type="text"/> If exposure > 1 day, date exposure ended <input style="width: 100px;" type="text"/> Description of exposure event <input style="width: 100%;" type="text"/>		
<b>First setting where exposure occurred</b> <span style="float: right;">Setting unknown <input type="checkbox"/> </span> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="radio"/> <b>Food premises</b>  <input type="radio"/> Restaurant/café/bakery  <input type="radio"/> Takeaway  <input type="radio"/> Supermarket/delicatessen  <input type="radio"/> Temporary or mobile service  <input type="radio"/> Fast food restaurant  <input type="radio"/> Caterers  <input type="radio"/> Other food outlet         </div> <div style="width: 30%;"> <input type="radio"/> <b>Institution</b>  <input type="radio"/> Hostel/boarding house  <input type="radio"/> Hotel/motel  <input type="radio"/> Long term care facility  <input type="radio"/> Hospital (acute care)  <input type="radio"/> Prison  <input type="radio"/> Camp  <input type="radio"/> School <input type="radio"/> Childcare centre  <input type="radio"/> Marae  <input type="radio"/> Other institution         </div> <div style="width: 30%;"> <input type="radio"/> <b>Workplace/Community/Other</b>  <input type="radio"/> Workplace  <input type="radio"/> Farm  <input type="radio"/> Petting zoo  <input type="radio"/> Home  <input type="radio"/> Community, church, sports gathering  <input type="radio"/> Cruise ship, airline, tour bus, train  <input type="radio"/> Other setting         </div> </div>		
<b>Setting name</b> <input style="width: 100%;" type="text"/>		
<b>Setting Address</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 20%;">Number <input style="width: 50px;" type="text"/></div> <div style="width: 40%;">Street <input style="width: 150px;" type="text"/></div> <div style="width: 20%;">Suburb <input style="width: 100px;" type="text"/></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 40%;">Town/City <input style="width: 150px;" type="text"/></div> <div style="width: 20%;">Post Code <input style="width: 50px;" type="text"/></div> <div style="width: 40%;"><input type="checkbox"/> GeoCode <input style="width: 50px;" type="text"/></div> </div>		
<b>Second setting where exposure occurred</b> <span style="float: right;">Setting unknown <input type="checkbox"/></span> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="radio"/> <b>Food premises</b>  <input type="radio"/> Restaurant/café/bakery  <input type="radio"/> Takeaway  <input type="radio"/> Supermarket/delicatessen  <input type="radio"/> Temporary or Mobile Service  <input type="radio"/> Fast food restaurant  <input type="radio"/> Caterers  <input type="radio"/> Other food outlet         </div> <div style="width: 30%;"> <input type="radio"/> <b>Institution</b>  <input type="radio"/> Hostel/boarding house  <input type="radio"/> Hotel/motel  <input type="radio"/> Long term care facility  <input type="radio"/> Hospital (acute care)  <input type="radio"/> Prison  <input type="radio"/> Camp  <input type="radio"/> School <input type="radio"/> Childcare centre  <input type="radio"/> Marae  <input type="radio"/> Other institution         </div> <div style="width: 30%;"> <input type="radio"/> <b>Workplace/Community/Other</b>  <input type="radio"/> Workplace  <input type="radio"/> Farm  <input type="radio"/> Petting zoo  <input type="radio"/> Home  <input type="radio"/> Community, church, sports gathering  <input type="radio"/> Cruise ship, airline, tour bus, train  <input type="radio"/> Other setting         </div> </div>		
<b>Setting name</b> <input style="width: 100%;" type="text"/>		
<b>Setting Address</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 20%;">Number <input style="width: 50px;" type="text"/></div> <div style="width: 40%;">Street <input style="width: 150px;" type="text"/></div> <div style="width: 20%;">Suburb <input style="width: 100px;" type="text"/></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 40%;">Town/City <input style="width: 150px;" type="text"/></div> <div style="width: 20%;">Post Code <input style="width: 50px;" type="text"/></div> <div style="width: 40%;"><input type="checkbox"/> GeoCode <input style="width: 50px;" type="text"/></div> </div>		

Outbreak Summary		Outbreak No. <input style="width: 150px;" type="text"/>	
<b>Circumstances of Exposure/Transmission contd</b>			
<b>First setting where contaminated food/beverage was prepared</b>			Setting unknown <input type="checkbox"/> <span style="float: right;">?</span>
<div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> <b>Overseas manufacturer, specify</b> <input style="width: 150px;" type="text"/> </div> <div> <input type="radio"/> <b>Food premises</b> </div> <div> <input type="radio"/> <b>Institution</b> </div> <div> <input type="radio"/> <b>Workplace/Community/Other</b> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <input type="radio"/> Restaurant/café/bakery  <input type="radio"/> Takeaway  <input type="radio"/> Supermarket/delicatessen  <input type="radio"/> Temporary or Mobile Service  <input type="radio"/> Fast food restaurant  <input type="radio"/> Caterers  <input type="radio"/> Other food outlet         </div> <div> <input type="radio"/> Hostel/boarding house  <input type="radio"/> Hotel/motel  <input type="radio"/> Long term care facility  <input type="radio"/> Hospital (acute care)  <input type="radio"/> Prison  <input type="radio"/> Camp  <input type="radio"/> School    <input type="radio"/> Childcare centre  <input type="radio"/> Marae  <input type="radio"/> Other institution         </div> <div> <input type="radio"/> Workplace  <input type="radio"/> Farm  <input type="radio"/> Petting zoo  <input type="radio"/> Home  <input type="radio"/> Community, church, sports gathering  <input type="radio"/> Cruise ship, airline, tour bus, train  <input type="radio"/> Commercial food manufacturer  <input type="radio"/> Other setting         </div> </div>			
<b>Setting name</b> <input style="width: 250px;" type="text"/> <b>Setting Address</b> Number <input style="width: 50px;" type="text"/> Street <input style="width: 150px;" type="text"/> Suburb <input style="width: 150px;" type="text"/> Town/City <input style="width: 200px;" type="text"/> Post Code <input style="width: 60px;" type="text"/> <input type="checkbox"/> GeoCode <input style="width: 40px;" type="text"/>			
<b>Second setting where contaminated food/beverage was prepared</b>			Setting unknown <input type="checkbox"/>
<div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> <b>Overseas manufacturer, specify</b> <input style="width: 150px;" type="text"/> </div> <div> <input type="radio"/> <b>Food premises</b> </div> <div> <input type="radio"/> <b>Institution</b> </div> <div> <input type="radio"/> <b>Workplace/Community/Other</b> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <input type="radio"/> Restaurant/café/bakery  <input type="radio"/> Takeaway  <input type="radio"/> Supermarket/delicatessen  <input type="radio"/> Temporary or Mobile Service  <input type="radio"/> Fast food restaurant  <input type="radio"/> Caterers  <input type="radio"/> Other food outlet         </div> <div> <input type="radio"/> Hostel/boarding house  <input type="radio"/> Hotel/motel  <input type="radio"/> Long term care facility  <input type="radio"/> Hospital (acute care)  <input type="radio"/> Prison  <input type="radio"/> Camp  <input type="radio"/> School    <input type="radio"/> Childcare centre  <input type="radio"/> Marae  <input type="radio"/> Other institution         </div> <div> <input type="radio"/> Workplace  <input type="radio"/> Farm  <input type="radio"/> Petting zoo  <input type="radio"/> Home  <input type="radio"/> Community, church, sports gathering  <input type="radio"/> Cruise ship, airline, tour bus, train  <input type="radio"/> Commercial food manufacturer  <input type="radio"/> Other setting         </div> </div>			
<b>Setting name</b> <input style="width: 250px;" type="text"/> <b>Setting Address</b> Number <input style="width: 50px;" type="text"/> Street <input style="width: 150px;" type="text"/> Suburb <input style="width: 150px;" type="text"/> Town/City <input style="width: 200px;" type="text"/> Post Code <input style="width: 60px;" type="text"/> <input type="checkbox"/> GeoCode <input style="width: 40px;" type="text"/>			
<b>Geographic location where exposure occurred (tick one)</b> <span style="float: right;">?</span>			
<input type="radio"/> New Zealand <input type="radio"/> Overseas, specify <input style="width: 150px;" type="text"/> <input type="radio"/> Unknown			
If exposure occurred in New Zealand, specify			
Primary TA <input style="width: 150px;" type="text"/> DHB(s) <input style="width: 150px;" type="text"/> <input style="width: 150px;" type="text"/> <input style="width: 150px;" type="text"/> <input style="width: 150px;" type="text"/> <input style="width: 150px;" type="text"/>			

Outbreak Summary	Outbreak No. <input style="width: 90%;" type="text"/>
<b>Circumstances of Exposure/Transmission contd</b>	
<b>Mode of transmission</b> (indicate the primary mode and all secondary modes) <span style="float: right;">?</span>	
<input type="checkbox"/> Foodborne, from consumption of contaminated food or drink (excluding water)	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
<input type="checkbox"/> Waterborne, from consumption of contaminated drinking water	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
<input type="checkbox"/> Person to person spread, from (non-sexual) contact with an infected person (including droplets)	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
<input type="checkbox"/> Sexual, from sexual contact with an infected person	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
<input type="checkbox"/> Parenteral, from needle stick injury or reuse of contaminated injection equipment	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
<input type="checkbox"/> Environmental, from contact with an environmental source (eg swimming)	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
<input type="checkbox"/> Zoonotic, from contact with an infected animal	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
<input type="checkbox"/> Vectorborne, from contact with an insect vector	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
<input type="checkbox"/> Other mode of transmission (specify) <input style="width: 350px;" type="text"/>	
Mode <input type="radio"/> primary <input type="radio"/> secondary	Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4
Mode of transmission unknown <input type="checkbox"/>	
<b>Vehicle/source of common source outbreak</b> <span style="float: right;">?</span>	
Was a specific contaminated food, water or environmental vehicle/source identified? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes,	
Source 1 <input style="width: 550px;" type="text"/>	
Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4	
Food category <input style="width: 150px;" type="text"/>	ESR Updated <input type="checkbox"/> Date <input style="width: 100px;" type="text"/>
Source 2 <input style="width: 550px;" type="text"/>	
Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4	
Food category <input style="width: 150px;" type="text"/>	ESR Updated <input type="checkbox"/> Date <input style="width: 100px;" type="text"/>
Source 3 <input style="width: 550px;" type="text"/>	
Level of evidence <input type="radio"/> 1 <input type="radio"/> 2a <input type="radio"/> 2b <input type="radio"/> 3a <input type="radio"/> 3b <input type="radio"/> 3c <input type="radio"/> 4	
Food category <input style="width: 150px;" type="text"/>	ESR Updated <input type="checkbox"/> Date <input style="width: 100px;" type="text"/>

Outbreak Summary	Outbreak No. <span style="border: 1px solid black; display: inline-block; width: 100px; height: 1.2em; vertical-align: middle;"></span>
<b>Factors Contributing to Outbreak</b> <span style="float: right; border: 1px solid black; border-radius: 50%; padding: 2px 5px;">?</span>	
<b>Foodborne outbreak</b> (tick all that apply)	
<input type="checkbox"/> Inadequate reheating of previously cooked food	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Improper storage prior to presentation	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Inadequate thawing	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Preparation too far in advance	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Undercooking	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Improper hot holding	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Inadequate or slow cooling or refrigeration	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Cross contamination due to improper handling or storage	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Cross contamination from an infected food handler	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Chemical contamination	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Use of ingredient from an unsafe source	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Use of untreated water in food preparation	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Consumption of unpasteurised milk	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Consumption of raw food	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Other factors, specify <span style="border: 1px solid black; display: inline-block; width: 150px; height: 1.2em; vertical-align: middle;"></span>	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<b>Waterborne outbreak</b> (tick all that apply)	
(Pre latest form revision: <input type="checkbox"/> Untreated water supply)	
<input type="checkbox"/> Surface water with no treatment	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Roof collected rainwater with no treatment	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Groundwater not assessed as secure and with no treatment	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Source water quality inferior to normal,	<input type="radio"/> Confirmed <input type="radio"/> Suspected
If source water quality inferior to normal, specify <span style="border: 1px solid black; display: inline-block; width: 250px; height: 1.2em; vertical-align: middle;"></span>	
<input type="checkbox"/> Inadequately treated water supply	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Recent or ongoing treatment process failure	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Contamination of post treatment water storage	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Post treatment contamination (other)	<input type="radio"/> Confirmed <input type="radio"/> Suspected
If post treatment contamination (other), specify <span style="border: 1px solid black; display: inline-block; width: 250px; height: 1.2em; vertical-align: middle;"></span>	
Specify the WINZ supply code of the implicated water supply	<span style="border: 1px solid black; display: inline-block; width: 150px; height: 1.2em; vertical-align: middle;"></span>
<b>Person to person outbreak</b> (tick all that apply)	
<input type="checkbox"/> Inadequate vaccination cover	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Inadequate vaccination effectiveness	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Exposure to infected person	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Poor hygiene of cases	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Excessively crowded living conditions	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Unprotected sexual activity	<input type="radio"/> Confirmed <input type="radio"/> Suspected
<input type="checkbox"/> Compromised immune system	<input type="radio"/> Confirmed <input type="radio"/> Suspected

Outbreak Summary		Outbreak No.
<b>Factors Contributing to Outbreak</b>		
<b>Environmental outbreak</b> (tick all that apply)		
<input type="checkbox"/> Exposure to contaminated land	<input type="radio"/> Confirmed	<input type="radio"/> Suspected
<input type="checkbox"/> Exposure to contaminated air (including ventilation)	<input type="radio"/> Confirmed	<input type="radio"/> Suspected
<input type="checkbox"/> Exposure to contaminated built environments (inc dwellings)	<input type="radio"/> Confirmed	<input type="radio"/> Suspected
<input type="checkbox"/> Exposure to infected animals or animal products	<input type="radio"/> Confirmed	<input type="radio"/> Suspected
<input type="checkbox"/> Exposure to contaminated swimming/spa pools	<input type="radio"/> Confirmed	<input type="radio"/> Suspected
<input type="checkbox"/> Exposure to contaminated other recreational water	<input type="radio"/> Confirmed	<input type="radio"/> Suspected
<b>Other outbreaks</b>		
<input type="checkbox"/> Other risk factor, specify	<input type="radio"/> Confirmed	<input type="radio"/> Suspected
<b>Management of the Outbreak</b>		
<b>Was there any specific action taken to control the outbreak?</b>		
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
<b>If yes, list the control measures undertaken</b> (tick all that apply)		
<b>Source</b>	<b>Specify</b>	
<input type="checkbox"/> Closure		
<input type="checkbox"/> Modification of procedures		
<input type="checkbox"/> Cleaning, disinfection		
<input type="checkbox"/> Removal		
<input type="checkbox"/> Treatment		
<input type="checkbox"/> Exclusion		
<input type="checkbox"/> Isolation		
<input type="checkbox"/> Health education and advice		
<input type="checkbox"/> Health warning		
<b>Vehicles and vectors</b>		
<input type="checkbox"/> Removal		
<input type="checkbox"/> Treatment		
<b>Contacts and potential contacts</b>		
<input type="checkbox"/> Chemoprophylaxis		
<input type="checkbox"/> Vaccination		
<input type="checkbox"/> Health education and advice		
<b>Other control measures</b> (specify)		

Outbreak Summary	Outbreak No.	
<b>Management of the Outbreak</b>		
Was insufficient information supplied to complete the form?	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Unknown
Other comments on outbreak		
<div></div>		
Please attach a copy of written report if prepared.		