**Les situations d’éclosion suivantes doivent être déclarées à la Direction de santé publique de la Montérégie (veuillez cocher la situation concernée) :**

Augmentation de l’incidence des cas de SARM colonisés ou infectés (hospitalier ou communautaire) transmis sur une unité de soins par rapport au taux attendu pour cette unité et qui perdure pour deux périodes administratives consécutives ou plus;

Deux cas ou plus de SARM (colonisation ou infection) rencontrés chez une clientèle inhabituelle (ex. bébés à la pouponnière, grands brûlés) ou lors de toute autre situation particulière (ex. souche communautaire en milieu de vie);

Présence, dans un même établissement de soins de longue durée, de deux nouveaux cas d’une infection grave causée par la même souche de SARM transmise en milieu de soins et nécessitant une chirurgie ou une antibiothérapie intraveineuse d’une durée de plus de 14 jours. La transmission doit survenir à l’intérieur de 1 mois (définition de la MADO).

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| **A. Identification** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nom de l’installation :** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | **No Mado :** | | | | | |  | | | | |  | | | |
| **Adresse :** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
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| **Nom du CSSS :** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
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| **Type d’installation :** | | | | | | | **Hôpital** | | | | | | | | | | | | | | | **RNI - Relié à l’établissement :** | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | |
| **CH public** | | | | | | | | | | | | | | | **Résidence privée pour personnes âgées** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CH privé conv.** | | | | | | | | | | | | | | | **Autres :** | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| **CH privé non conv.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Date de déclaration :** | | | | | **/** **/** | | | | | | | | | | | | | | **(A/M/J)** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Complété par :** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | **Titre :** | | | | | |  | | | | | | | | | | | | |  | | | | | | | |
| **Téléphone :** | |  | | | | | | | | | | | | | **Poste :** | | | | | | | |  | | | | | | | |  | | **Télécopieur :** | | | | | | | | | |  | | | | | | | | |  | | | | |
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| **B. Éclosion** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Unité touchée par l’éclosion :** | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date de début de l’éclosion :** | | | | | | | | | | **/       /** | | | | | | | | | | | | | | | **(A/M/J)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Circonstance de la découverte de l’éclosion :** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| **Pour un total de** | | |  | | | | | **cas de SARM d’acquisition nosocomiale sur une période de** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | **jours** | | | | | | | | | | | |
|  | | | **Nb** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Nb** | | | | | |  | | | | | | | | | | | |
| **S’agit-il de cas :** | | | Colonisés | | | | | | | |  | | Nombre : | | |  | | | | | | | |  | | | | Infectés | | | | | |  | | | Nombre : | | | | | | |  | | |  | | | | | | | | | |
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| **C. Fin d’éclosion** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Nombre de cas colonisés :** | | | | | | | | |  | | | | | | | | |  | | **Nombre de cas infectés :** | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |
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| **À l’usage de la DSP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date de réception : | | | | | | **/       /** | | | | | | | | | | | | | | | **(A/M/J)** | | | | | | | | | | | **Par :** | | | | | |  | | | | | | | | | | | | | | | | | |  |
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**Acheminer à la DSP ce formulaire dûment complété par courriel ou par télécopieur**

**Télécopieur : 450 928-3023 Adresse courriel : equipe.noso.agence16@ssss.gouv.qc.ca**