

## Shiga Toxin-Producing *Escherichia coli* (*E. coli*) and/or Hemolytic Uremic Syndrome (HUS) Investigation Form

Texas Department of State Health Services Infectious Disease Control Unit 1100 W. 49<sup>th</sup> St., Austin, TX 78756 (512) 458-7676 (512) 458-7616 fax

	Name:						
P A	Last			First		MI	
т	Address:			<del></del>		_	
I E	Street			City			
N T	County		State	Zip Code	() Phone#		
Т	DOB:/ Age: Sex:		Ethnicity	H-Hispania or La	otino: N-not Hignori	a or Latina, U-Unknown	
	Race: W=White; B=Black/African American; N=Am	nerica	n Indian/Alaska Native;	; P=Native Hawaiian	n/Pacific Islander; A	=Asian; O=Other; U=Unknown	
	Occupation:						
	If day care, early childhood development, or	food :	service position includ	le name and addres	s of employer.		
s Y	Onset Date:// Check all that apply:	L A					
М	☐ Diarrhea	В	_			late:/	
P T	☐ Bloody diarrhea ☐ Hospitalized	D				men#:	
0		A T	Culture results/is	olate identificatio	on:	Result status:	
М О	Hospital Name	A	☐ Escherichia coli (E. coli) ☐ Preliminary   ☐ E. coli O157 ("H" unknown, or not H7) ☐ Final   ☐ E. coli O157:H7 ☐ E. coli not O157 If known, serotype:   ☐ Other: ☐ Negative / no pathogens				
T	/						
L	Admit Date Discharge Date						
O G	Died Date of Death:/						
Y	☐ Thrombotic thrombocytopenic purpura (TTP) (postdiarrheal only)		☐ Not done				
	(postdiarrhear only)  Hemolytic uremic syndrome (HUS) (postdiarrhear only)		☐ Elevated STEC antibody titer Specify serotype:				
	If HUS or TTP, check all that apply:  ☐ Acute anemia		Toxin test results:	:			
	☐ Microangiopathic changes on peripheral				ga-like toxin posi bhemorrhagic E.c		
	blood smear ☐ Renal (kidney) injury or failure		☐ Negative / no t		memorrnagic E.c	on LIA positive)	
	☐ Hematuria (blood in urine)						
	☐ Proteinuria (excess protein in urine) ☐ Elevated creatinine Value: mg/dL		PFGE results:				
	☐ Dialysis required		PCR results:	uidA 🗌 Stx I	☐ Stx II ☐ ea	aeA	
T R E A	Was the patient treated with antibiotics or antimotilit	ty dr	ugs for this illness? Start Date	YES NO	If YES, complete Enc	e the following: d Date	
M E							
N							
T							
E X	Medical	Risk	x Factors (Please ch	eck all that apply	7)		
P O	Antibiotic use within 30 days of onset; please name:						
s U	☐ Chronic medications, please name:						
R E S	☐ Immunocompromised? If yes, with what?						

Ground heef (e.g., picnic, barbeque). Where?    Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where?   Counter ground heef (e.g., picnic, barbeque). Where and date(s):   Counter ground heef (e.g., picnic, barbeque). Where and date(s):   Counter with dispered children   Counter with dispered children   Counter with someone who has districted. Who?   Exposure to animal water   Recreational water exposure. Where and when?   Exposure to investock   Exposure to positry   Exposure to evotic pets. Type of pet(s):   Does the patient work at or attend a day care center? YES NO If YES, complete the following:   Name of disperent ground		Suspect Foods (Please check all that apply)							
Other ground heef (e.g., pienie, barbeque), Where?		☐ Ground beef at home. Brand and where purchased:							
Ground bed from restaurant. Where?    Ground bed from restaurant. Where?   Contact with diapered children   Contact with diapered ch	P	☐ Other ground beef (e.g., picnic, barbeque). Where?							
Unpasteurized fruit juices. Please identify:		Ground beef from restaurant. Where?							
Unpasteurized fruit juries. Please identify:		Raw milk or unpasteurized dairy products. Please identify:							
Sprouts. Please specify:		☐ Unpasteurized fruit juices. Please identify:							
Sylvinis, Prease specify:		☐ Fresh produce from farm or home garden. Please identify:							
Other Please specify:		☐ Sprouts. Please specify:							
Food sample Information  Food samples submitted to DSHS? VFS NO Food sample type:		Other. Please specify:							
Organisms isolated from food:	A								
Other Potential Risk Factors (Please check all that apply)    Travel prior to illness onset. Destination(s) and date(s):     Contact with diapered children   Contact with omeone who has diarrhea. Who?     Exposure to animal waste     Recreational water exposure. Where and when?     Exposure to poultry     Exposure to poultry     Exposure to poultry     Exposure to exotic pets. Type of pet(s):     Does the patient work at or attend a day care center? YES NO   If YES, complete the following:     Name of day care center:   Address:     Were other children or staff ill? YES NO   If YES, were they: Cultured? YES NO   Excluded from attendance? YES NO     If YES, complete the following:     How many household contacts does the patient have?   Have any of these had a diarrheal illness? YES NO     If YES, complete the following:     Last:   First:   DOB:   Onset date:   Culture positive? YES NO     Last:   First:   DOB:   Onset date:   Culture positive? YES NO     Last:   First:   DOB:   Onset date:   Culture positive? YES NO     Last:   First:   DOB:   Onset date:   Culture positive? YES NO     Cooled the patient of the policy of the patient of the positive? YES NO     Cooled the patient of the	_	Food samples submitted to DSHS? YES NO Food sample type:							
Travel prior to illness onset. Destination(s) and date(s):  Contact with diapered children  Contact with someone who has diarrhea. Who?  Exposure to animal waste  Recreational water exposure. Where and when?  Exposure to poultry  Exposure to poultry  Exposure to poultry  Exposure to poultry  Exposure to exotic pets. Type of pet(s):  Does the patient work at or attend a day care center? YES NO If YES, complete the following:  Name of day care center:  Name of director:  Name of director:  Phone #; ()  Were other children or staff ill? YES NO Associated with another case? YES NO Excluded from attendance? YES NO If YES, complete the following:  Have any of these had a diarrheal illness? YES NO If YES, complete the following:  Last:  First:  DOB:  Onset date:  Culture positive? YES NO Last:  First:  DOB:  Onset date:  Culture positive? YES NO Culture positive? YES NO DOB:  DOB:  Onset date:  Culture positive? YES NO DOB:  Culture positive? YES NO DOB:		Organisms isolated from food: Did food sample PFGE match patient PFGE? YES NO							
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Contact with someone who has diarrhea. Who?  Exposure to animal waste  Recreational water exposure. Where and when?  Exposure to livestock  Exposure to exotic pets. Type of pet(s):  Does the patient work at or attend a day care center? YES NO If YES, complete the following:  Name of day care center:  Name of day care center:  Vere other children or staff ill? YES NO If YES, were they: Cultured? YES NO Excluded from attendance? YES NO If YES, complete the following:  Name of director:  Name of day care center?  Name of director:  Name of day care center?  Name of day care center:  Name of day care c		☐ Travel prior to illness onset. Destination(s) and date(s):							
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