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. 49th St., Austin, TX 78756
(512) 458-7676 (512) 458-7616 fax

PATIENT

Name: _____ _____ _____
Last First MI

Address: _____ _____
Street City

_____ _____ _____ (_____)_____
County State Zip Code Phone#

DOB: _____/_____/_____ **Age:** _____ **Sex:** _____ **Ethnicity:** _____ H=Hispanic or Latino; N=not Hispanic or Latino; U=Unknown

Race: _____ W=White; B=Black/African American; N=American Indian/Alaska Native; P=Native Hawaiian/Pacific Islander; A=Asian; O=Other; U=Unknown

Occupation: _____

If day care, early childhood development, or food service position include name and address of employer.

SYMPTOMOTOLOGY

Onset Date: _____/_____/_____

Check all that apply:

- ☐ Diarrhea
- ☐ Bloody diarrhea
- ☐ Hospitalized

_____
Hospital Name

_____/_____/_____ _____/_____/_____
Admit Date Discharge Date

- ☐ Died **Date of Death:** _____/_____/_____
- ☐ Thrombotic thrombocytopenic purpura (TTP) (postdiarrheal only)
- ☐ Hemolytic uremic syndrome (HUS) (postdiarrheal only)

If HUS or TTP, check all that apply:

- ☐ Acute anemia
- ☐ Microangiopathic changes on peripheral blood smear
- ☐ Renal (kidney) injury or failure
  - ☐ Hematuria (blood in urine)
  - ☐ Proteinuria (excess protein in urine)
  - ☐ Elevated creatinine Value: _____mg/dL
- ☐ Dialysis required

LAB DATA

Laboratory name: _____

Specimen source: _____ **Collection date:** _____/_____/_____

Sent to DSHS (state lab)? YES NO **DSHS specimen#:** _____

Culture results/isolate identification: **Result status:**

- ☐ *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
- ☐ Not done

- ☐ Elevated STEC antibody titer **Specify serotype:** _____

Toxin test results:

- ☐ Shiga toxin demonstrated / Shiga-like toxin positive
- ☐ EIA assay positive (e.g., Enterohemorrhagic E.coli EIA positive)
- ☐ Negative / no toxin

PFGE results: _____

PCR results: ☐ uidA ☐ Stx I ☐ Stx II ☐ eaeA ☐ hly ☐ negative

TREATMENT

Was the patient treated with antibiotics or antimotility drugs for this illness? YES NO If YES, complete the following:

Drug	Start Date	End Date

EXPOSURES

Medical Risk Factors (Please check all that apply)

- ☐ **Antibiotic use within 30 days of onset; please name:** _____
- ☐ **Chronic medications, please name:** _____
- ☐ **Immunocompromised? If yes, with what?** _____

EXPOSURE DATA

Suspect Foods (Please check all that apply)

- ☐ **Ground beef at home. Brand and where purchased:** _____
- ☐ **Other ground beef (e.g., picnic, barbeque). Where?** _____
- ☐ **Ground beef from restaurant. Where?** _____
- ☐ **Raw milk or unpasteurized dairy products. Please identify:** _____
- ☐ **Unpasteurized fruit juices. Please identify:** _____
- ☐ **Fresh produce from farm or home garden. Please identify:** _____
- ☐ **Sprouts. Please specify:** _____
- ☐ **Other. Please specify:** _____

Food Sample Information

Food samples submitted to DSHS? YES NO **Food sample type:** _____

Organisms isolated from food: _____ **Did food sample PFGE match patient PFGE? YES NO**

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 someone who has diarrhea. Who?** _____
- ☐ **Exposure to animal waste**
- ☐ **Recreational water exposure. Where and when?** _____
- ☐ **Exposure to livestock**
- ☐ **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:** _____

Name of director: _____ **Phone #: (_____)**_____

Were other children or staff ill? YES NO If YES, were they: Cultured? YES NO Excluded from attendance? YES NO

CONTACTS

Is this case: Part of an outbreak? YES NO Associated with another case? YES NO Identify case: _____

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**

COMMENTS

Reported by: _____ **Phone: (_____)**_____ **Date Reported:** _____/_____/_____

Investigated by: _____ **Investigation Start Date:** _____/_____/_____

Agency: _____ **Phone: (_____)**_____

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