Escherichia coli O157 (and other STEC)

COUNTY

FOR STATE USE ONLY #

___/___/___ case report ☐ confirmed ☐ presumptive

___/___/___ interstate ☐ suspect

Date investigation initiated _____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

e-mail _____ Language spoken _____

ALTERNATIVE CONTACT: ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT *(check all that apply)*

☐ Lab ☐ Infection Control Practitioner

☐ Physician ☐ _____

Name _____

Phone _____ Date ___/___/___
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient? ☐

DEMOGRAPHICS

SEX

☐ female ☐ male

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____

HISPANIC ☐ yes ☐ no ☐ unknown

RACE

☐ White ☐ American Indian

☐ Black ☐ Asian/Pacific Islander

☐ unknown ☐ refused to answer

☐ other _____

Worksites/school/day care center _____

_____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic: ☐ yes ☐ no ☐ unk

if yes, ONSET on ____/____/____
m d y

Check all that apply:

diarrhea ☐ yes ☐ no ☐ unk

bloody diarrhea ☐ yes ☐ no ☐ unk

HUS ☐ yes ☐ no ☐ unk

TTP ☐ yes ☐ no ☐ unk

Hospitalized: ☐ yes ☐ no ☐ unk

name of hospital _____

date of admission ____/____/____
m d y

date of discharge ____/____/____
m d y

Transferred to another hospital:

☐ yes ☐ no ☐ unk

transfer hospital name _____

Outcome: ☐ survived ☐ died ☐ unk

date of death ____/____/____
m d y

LABORATORY DATA

Shiga-toxin positive: ☐ yes ☐ no

Culture confirmed: ☐ yes ☐ no

if yes, Lab _____

Specimen collected ____/____/____
m d y

submitted to PHL ☐ yes ☐ no ☐ unk

PHL specimen # _____

flagella:

☐ H7 ☐ non-motile ☐ _____

toxin type:

☐ SLT1 ☐ SLT2 ☐ not done

EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak? ☐ yes ☐ no ☐ unk

a close contact of a ***confirmed*** or ***presumptive*** case? ☐ yes ☐ no ☐ unk

Has the above case been reported? ☐ yes ☐ not yet

Specify nature of contact:

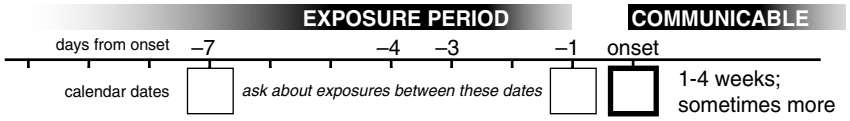
☐ household ☐ sexual ☐ daycare ☐ _____

if yes to any question, specify relevant names, dates, places, etc:

PATIENT'S NAME ▸ _____

INFECTION TIMELINE

Enter onset date in heavy box. Count back to figure the probable exposure period.



POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Skip this section if the case is already epi-linked.

☐ **no risk factors could be identified**

☐ **patient could not be interviewed**

SUSPECT FOODS

	yes	no	
a	☐	☐	undercooked/raw meat (esp. hamburger)
b	☐	☐	ANY ground beef
c	☐	☐	food at restaurants
d	☐	☐	food at other gatherings (potlucks, events)
e	☐	☐	dried meat (salami, jerky, etc.)
f	☐	☐	raw milk/other unpasteurized dairy products
g	☐	☐	venison or other game (*Leftovers??**)
h	☐	☐	sprouts (alfalfa, clover, bean, ...)
i	☐	☐	unpasteurized juice/cider

OTHER POTENTIAL SOURCES

	yes	no	
m	☐	☐	work exposure to human or animal excreta
n	☐	☐	contact with diapered children
o	☐	☐	recreational water exposure (lakes, rivers, kiddie pools, etc.)
p	☐	☐	livestock or farm exposure
q	☐	☐	animal exhibits (petting zoos, fairs, 4H, etc.)
r	☐	☐	travel outside U.S. departure date ___ /___ /___ return date ___ /___ /___
s	☐	☐	other travel departure date ___ /___ /___ return date ___ /___ /___
x	☐	☐	_____

*http://www.oshd.org/cdpe/guideln/forms/meatform.pdf

Provide details (places, dates) about possible sources and risk factors checked above.

TREATMENT Was patient treated with antibiotics or antimotility drugs for this illness? ☐ yes ☐ no

if yes, specify type, dose, and dates given:

CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER

name	age	occupation	diarrhea	onset date m/ d/ y	education provided	comments
			yes ☐ no ☐ unk ☐		yes ☐ no ☐ unk ☐	
			☐ ☐ ☐		☐ ☐ ☐	
			☐ ☐ ☐		☐ ☐ ☐	
			☐ ☐ ☐		☐ ☐ ☐	

Does the case know about anyone else with a similar illness? ☐ yes ☐ no ☐ could not be interviewed

if yes, give names, onset dates, contact information, and other details.

If the case is a food handler, HCW with direct patient contact, or works at or attends daycare, provide details about site, job description, dates worked/attended during communicable period (if applicable), supervisor, etc.

If the patient attends daycare or nursery school, conduct active surveillance for additional cases.

Contact person/phone number:

Is the patient in diapers? ☐ yes ☐ no

Are other children or staff ill? ☐ yes ☐ no

Dates contacted: ____/____/____ (m d y)

SUMMARY OF FOLLOW-UP AND COMMENTS. Provide details as appropriate.

☐ hygiene education provided ☐ work or daycare restriction for case ☐ daycare inspection

☐ testing of home/other water supply ☐ restaurant inspection ☐ _____

D

ADMINISTRATION

E.coli O157/March 2004

Remember to copy patient's name to the top of this page.

Initial report sent to OHS on ____/____/____

Completed by _____ Date _____ Phone _____ Case investigation sent to OHS on ____/____/____