Enteric Disease Investigation Form
for reporting Hemolytic Uremic Syndrome (HUS) and/or E. coli O157:H7
Texas Department of Health
Infectious Disease Epidemiology and Surveillance Division
Austin, Texas (512) 458-7676

| PATIENT | Name: ____________________________________________ Last ______________ First ___________________ MI _______ |
| Address: __________________________________________ Street __________________ City ___________________
| __________________________________________ County __________________ State __________ Zip Code __________ (____) __________ Phone # __________ |
| DOB: ______________ Age: ______ Sex: ______ Race: ______ (W = white, B = Black, I = Am Indian, A = Asian, H = Hispanic, O = Other) |
| Occupation: If Day Care, Early Childhood Development, or Food Service position include name and address of employer. |

How many household contacts does the patient have? ______ Have any of these had a diarrheal illness? Yes No
If YES, complete the following information:

| Household | Last: ___________________ First: ___________________ Onset date: __________ Culture Positive? YES NO |
| Last: ___________________ First: ___________________ Onset date: __________ Culture Positive? YES NO |
| Last: ___________________ First: ___________________ Onset date: __________ Culture Positive? YES NO |

How was the patient infected?
Check all that apply:

- Diarrhea
- Bloody diarrhea
- Hospitalized Died YES NO
- Admit Date __________ Discharge Date __________
- Thrombotic thrombocytopenic purpura
- Hemolytic uremic syndrome (HUS)

Prior to and immediately after onset, was the patient:
- Associated with another case? YES NO
- Associated with an outbreak? YES NO
- Close contact of another case? YES NO

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

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<tr>
<th>Drug</th>
<th>Start date</th>
<th>End date</th>
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IDEAS Form 5, 08/98
**Medical Risk Factors** (Please check all those that apply)

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

**Suspect Foods** (Please check all those that apply)

- __ Ground beef at home. Brand and Where purchased: ________________________________
- __ Other ground beef (ex. picnic, barbeque). Where? ________________________________
- __ Ground beef from restaurant. Where? ________________________________
- __ Raw milk or other unpasteurized dairy products. Please name: ________________________________
- __ Unpasteurized fruit juices. Please name: ________________________________
- __ Fresh produce from farm or home garden. ________________________________
- __ Sprouts

**Food Sample Information**

Food samples submitted to TDH? 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 those that apply)

- __ 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. ________________________________

Does the patient work at or attend a day care center? YES NO

If yes,
Name of day care center: ________________________________ Address: ________________________________

Name of Director: ________________________________ Phone #: ________________________________

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

**Comment**

Investigated by: ________________________________ Phone: ________________________________
Agency: ________________________________ Date ________________________________