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.

HOUSEHOLD

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

Last: _____ **First:** _____ **Onset date:** _____ **Culture Positive? YES NO**

Last: _____ **First:** _____ **Onset date:** _____ **Culture Positive? YES NO**

Last: _____ **First:** _____ **Onset date:** _____ **Culture Positive? YES NO**

Last: _____ **First:** _____ **Onset date:** _____ **Culture Positive? YES NO**

SYMPTOMOLOGY

_____
Onset Date

Check all that apply:

___ **Diarrhea**

___ **Bloody diarrhea**

___ **Hospitalized** **Died YES NO**

_____ _____
Admit Date Discharge Date

___ **Thrombotic thrombocytopenic purpura**

___ **Hemolytic uremic syndrome (HUS)**

LAB DATA

Name/address of Lab:

_____

_____

_____

Organism isolated:

_____

Was isolate sent to TDH for confirmation/PFGE typing?
YES NO

LINKAGE

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

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
_____	_____	_____
_____	_____	_____

EXPOSURE DATA

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** _____