



Send completed forms to DOH Communicable Disease Epidemiology
 Fax: 206-418-5515

LHJ Use ID _____
 Reported to DOH Date ___/___/___
LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Other: _____
 Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____
 Date Received ___/___/___
DOH Classification
 Confirmed
 Probable
 No count; reason: _____

Enterohemorrhagic *E. coli*

County _____

REPORT SOURCE

Initial report date ___/___/___
 Reporter (check all that apply)
 Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No Don't know
 Investigation start date: ___/___/___
 Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____
 Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____
 Birth date ___/___/___ Age _____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other

CLINICAL INFORMATION

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y N DK NA
 Diarrhea Maximum # of stools in 24 hours: _____
 Bloody diarrhea
 Abdominal cramps or pain
 Nausea
 Vomiting
 Fever Highest measured temp (°F): _____
 Oral Rectal Other: _____ Unk

Hospitalization

Y N DK NA
 Hospitalized for this illness
 Hospital name _____
 Admit date ___/___/___ Discharge date ___/___/___
Y N DK NA
 Died from illness Death date ___/___/___
 Autopsy

Predisposing Conditions

Y N DK NA
 Antibiotic taken for this diarrheal illness
 Underlying illness, specify: _____

Laboratory

Collection date ___/___/___
Y N DK NA
 (Probable) Shigatoxin-positive, no isolation of *E. coli*
 ***E. coli* O157:H7 isolation**
 Shigatoxin-producing *E. coli* isolation
 Type if non-O157:H7 _____
 Elevated titer for EHEC Type: _____
 Food specimen submitted for testing

Clinical Findings

Y N DK NA
 Hemolytic uremic syndrome (HUS)
 Thrombotic thrombocytopenic purpura (TTP)
 Coagulopathy (platelets < 100,000)
 Acute anemia with microangiopathic changes
 Kidney (renal) abnormality or failure
 Resulting in kidney dialysis: Y N DK NA

NOTES

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:	Exposure period		o n s e t	Contagious period
	-8	-1		1 week to weeks
Calendar dates:	<input type="text"/>	<input type="text"/>	<input type="text"/>	

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case knows anyone with similar symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologic link to a confirmed human case</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with lab confirmed case <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Needle use <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with diapered or incontinent child or adult</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Beef Rare, undercooked, or raw: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ground beef Rare, undercooked, or raw: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Handled raw meat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Venison or other wild game meat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other meat products: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Raw fruits or vegetables</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sprouts (e.g. alfalfa, clover, bean)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fresh herbs Type: _____</p> <p><input type="checkbox"/> Patient could not be interviewed</p> <p><input type="checkbox"/> No risk factors or exposures could be identified</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized milk (cow)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Juices or cider, Type: _____ Unpasteurized: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Known contaminated food product</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Group meal (e.g. potluck, reception)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food from restaurants Restaurant name/location: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Source of home drinking water known <input type="checkbox"/> Individual well <input type="checkbox"/> Shared well <input type="checkbox"/> Public water system <input type="checkbox"/> Bottled water <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Drank untreated/unchlorinated water (e.g. surface, well)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case or household member lives or works on farm or dairy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Zoo, farm, fair or pet shop visit</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any contact with animals at home or elsewhere Cattle, cow or calf: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <input type="checkbox"/> NA</p>
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Most likely exposure/site: _____ Site name/address: _____

Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

PATIENT PROPHYLAXIS / TREATMENT

PUBLIC HEALTH ISSUES

Y N DK NA

Employed as food worker

Non-occupational food handling (e.g. potlucks, receptions) during contagious period

Employed as health care worker

Employed in child care or preschool

Attends child care or preschool

Household member or close contact in sensitive occupation or setting (HCW, child care, food)

Outbreak related

PUBLIC HEALTH ACTIONS

Exclude from sensitive occupation (HCW, food, child care) or situations (child care) until 2 negative stools

Hygiene education provided

Restaurant inspection

Child care inspection

Testing of home/other water supply

Initiate traceback investigation

Other, specify: _____

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ___/___/___

Local health jurisdiction _____