



Hemolytic Uremic Syndrome Surveillance State Department of Health

Case Report Form

Instructions: Complete the following by interviewing the attending physician and/or reviewing patient's medical record.

I. PATIENT IDENTIFICATION

1A. Patient name _____ last _____ first _____ 2A. Date of birth ____/____/____
mo / day / yr

3A. Parent/guardian _____ last _____ first _____ 4A. Medical Rec # _____

5A. Address _____
number/street _____ city _____ state _____ zip _____

6A. Phone home (____) _____ 7A. Phone work (____) _____ 8A. County of residence _____

9A. Sex Female Male

10A. Ethnicity Hispanic Non-Hispanic Unknown

11A. Race White Asian / Pacific Islander Black American Indian / Alaska Native

12A. How was patient's illness first identified by public health (state or local health department or EIP)?

Report of HUS case by a physician or service participating in the FoodNet HUS active surveillance network
Date Entered (MM/DD/YY): _____

Report of HUS case by a non-participating physician or service

Routine STEC infection surveillance

Other, describe _____

13A. Was this case captured through Hospital Discharge Data?
 Yes Date Entered (MM/DD/YY): _____
 No

Other _____ Unknown

II. HOSPITAL INFORMATION

14A. Person reporting case _____ 15A. Phone (____) _____

16A. Attending physician _____ 17A. Phone (____) _____

18A. Hospital _____ Name _____ City/State _____ 19A. Phone (____) _____

20A. Date of admission or transfer to this facility ____/____/____

21A. Date of discharge or transfer from this facility ____/____/____ Still hospitalized

22A. Institution transferred to (if applicable) _____
Name _____ City/State _____

23A. Institution where first hospitalized (if different) _____
Name _____ City/State _____

24A. Date of initial hospitalization (if different) ____/____/____

25A. Physician, initial hospitalization (if different) _____ 26A. Phone (____) _____



Public reporting burden of this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

- 29A. Did patient have diarrhea during the 3 weeks before HUS diagnosis?..... yes no unsure
if yes 30A. Date of diarrhea onset _____/_____/_____
 31A. Did stools contain visible blood at any time yes no unsure
 32A. Was diarrhea treated with antimicrobial medications..... yes no unsure
if yes 33A. Type of antimicrobial _____

_____ *If no to diarrhea* 34A. Did the patient have contact with another person with diarrhea or HUS during the 3 weeks before HUS diagnosis (include daycare, household, etc)? yes no unsure

- 35A. Was patient treated with an antimicrobial medication for any other reason than diarrhea during the 3 weeks before HUS diagnosis? yes no unsure
if yes 36A. Type of antimicrobial _____
 37A. Reason(s) _____

Other medical conditions present during 3 weeks before HUS diagnosis:

- 38A. Other gastrointestinal illness..... yes no unsure
 39A. Urinary tract infection yes no unsure
 40A. Respiratory tract infection yes no unsure
 41A. Other acute illness..... yes no unsure
if yes 42A. Describe _____
- 43A. Pregnancy yes no unsure
 44A. Kidney Disease yes no unsure
 45A. Immune compromising condition or medication yes no unsure
if yes 46A. Malignancy..... yes no unsure
 47A. Transplanted organ or bone marrow..... yes no unsure
 48A. HIV infection..... yes no unsure
 49A. Steroid Use (parenteral or oral)..... yes no unsure
 50A. Other, describe _____

Laboratory values within 7 days before and 3 days after HUS diagnosis:

- 51A. Highest serum creatinine..... _____ mg/dL
 52A. Highest serum BUN _____ mg/dL
 53A. Highest WBC _____ K/mm³
 54A. Lowest hemoglobin _____ g/dL
 55A. Lowest hematocrit _____ %
 56A. Lowest platelet count _____ K/mm³

57A. Microangiopathic changes (i.e., schistocytes, helmet cells or red cell fragments) at any time within 7 days before HUS diagnosis to hospital discharge (if patient was not hospitalized or discharged within 3 days of HUS diagnosis, then outpatient lab results from 7 days before to 3 days after diagnosis should be used, if available).

- yes no unsure not tested

Other laboratory findings within 7 days before and 3 days after HUS diagnosis:

- 58A. Blood (or heme) in urine..... yes no unsure not tested
 59A. Protein in urine..... yes no unsure not tested
 60A. RBC in urine by microscopy..... yes no unsure not tested

- 61A. Status of report _____ Initial _____ Update _____ Complete
 62A. Date ____/____/____ 63A. Completed by (initials) _____



**State Department of Health
Microbiology Report Form**

Instructions: Complete by contacting microbiology laboratory at each institution where patient's specimen was tested. Complete one composite form for all laboratories (includes hospital laboratories, outpatient laboratories, state public health laboratories and CDC).

1B. Was stool specimen obtained from this patient yes no unsure
if no Skip to question 20B

2B. Laboratories where stool(s) tested

_____	_____	Phone (____) _____
Name	City/State	
_____	_____	Phone (____) _____
Name	City/State	
_____	_____	Phone (____) _____
Name	City/State	
_____	_____	Phone (____) _____
Name	City/State	

3B. Was stool tested for Shiga toxin at any CLINICAL laboratory..... yes no unsure
if yes

4B. Result..... positive negative unsure

5B. Collection date of first specimen tested ____/____/____

6B. Collection date of 1st positive specimen: ____/____/____

7B. Was stool cultured for *E. coli* O157 (on selective or differential media e.g. SMAC, CHROMagar O157, CTSMAC) at any CLINICAL laboratory? yes no unsure

if yes 8B. Collection date 1st specimen culture for O157: ____/____/____

9B. Was *E. coli* O157 isolated?..... yes no unsure

if yes 10B. Collection date 1st positive specimen culture for O157: ____/____/____

11B. Result of H antigen testing (*check one*):

- H7 positive other H, specify: _____
- H7 negative
- unsure or not tested
- non-motile

12B. Was a stool sample, or any type of specimen or isolate originating from stool sent to a public health laboratory (state or CDC)? yes no unsure

if yes 13B. Date of specimen collection: ____/____/____

14B. Was *E. coli* O157 or non-O157 STEC identified? yes no unsure

if yes Strain 1: O antigen: _____ H antigen: _____
 Rough non-motile

undetermined not tested
 not tested

Strain 2: O antigen: _____ H antigen: _____
 Rough non-motile

undetermined not tested
 not tested

15B. Was immunomagnetic separation (IMS) used to identify common STEC serogroups? yes no unsure

if yes 16B. What serogroup(s) did the IMS procedure target? 1____, 2____, 3____, 4____, 5____,
6____, 7____



17B. Other pathogen isolated from stool (at PHL or clinical lab)..... yes no unsure

if yes 18B. Pathogen #1 _____ Specimen collection date ____/____/____
 19B. Pathogen #2 _____ Specimen collection date ____/____/____

20B. Pathogen isolated from source other than stool (at PHL or clinical lab)..... yes no unsure

if no Skip to 26B

if yes 21B. Pathogen _____
 22B. Specimen Source _____
 23B. First date of isolation ____/____/____

If O157 or other STEC was isolated, complete the following based on health department records:

24B. Disposition of isolate Sent to state laboratory (state laboratory ID # _____)
(check all that apply) Sent to CDC (ID, if different than SLABID, _____)
 Sent to other reference laboratory (specify _____)
 Discarded

25B. Is the patient a resident of the FoodNet catchment area? yes no

if yes 26B. FoodNet PersonID _____

27B. Has patient serum or plasma been sent to CDC for testing for antibodies to O157 or other STEC?..... yes no unsure

if no Skip to 29B

if yes
 28B. State laboratory ID for serum _____
 Other laboratory ID numbers for serum sent to CDC _____

LPS type	Titer IgG	Interpretation of IgG			Titer IgM	Interpretation of IgM			Not tested
		Positive	Negative	Borderline		Positive	Negative	Borderline	

29B. Status of report _____ initial _____ update _____ complete

30B. Date ____/____/____ 31B. Completed by (initials) _____



CASE ID _____



**Hemolytic Uremic Syndrome Surveillance
State Department of Health**

Chart Review Form

Instructions: Complete after patient has been discharged; use hospital discharge summary, consultation notes and DRG coding sheet. Complete one composite form for all institution where hospitalized.

1C. Hospitals admitted _____ Phone (____) _____
 Date admitted above: ___/___/___ Date discharged above: ___/___/___

_____ Phone (____) _____
 Date admitted above: ___/___/___ Date discharged above: ___/___/___

_____ Phone (____) _____
 Date admitted above: ___/___/___ Date discharged above: ___/___/___

_____ Phone (____) _____
 Date admitted above: ___/___/___ Date discharged above: ___/___/___

2C. Date of first admission: ___/___/___ 3C. Date of last discharge: ___/___/___

Did any of the following complications occur during this admission:

Date of onset

4C.	Pneumonia.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	CASE ID	_____	_____	_____	_____
6C.	Seizure.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	5C.	___/___/___	___/___/___	___/___/___
8C.	Paralysis or hemiparesis.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	7C.	___/___/___	___/___/___	___/___/___
10C.	Blindness.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	9C.	___/___/___	___/___/___	___/___/___
12C.	Other major neurologic sequelae	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	11C.	___/___/___	___/___/___	___/___/___
	<i>if yes, Describe:</i> _____								

Were any of the following procedures performed during this admission:

- 14C. Peritoneal dialysis..... yes no unsure
 15C. Hemodialysis..... yes no unsure

Transfusion with:

- 16C. packed RBC or whole blood..... yes no unsure
 17C. platelets..... yes no unsure
 18C. fresh frozen plasma..... yes no unsure

- 19C. Plasmapheresis yes no unsure
 20C. Laparotomy or other abdominal surgery*..... yes no unsure

(*other than insertion of dialysis catheter)

if yes 21C. Describe: _____

- 22C. Condition at discharge..... dead alive

if dead, 23C. Date deceased: ___/___/___

- if alive, 24C. Requiring dialysis..... yes no unsure

- 25C. With neurologic deficits..... yes no unsure

26C. Status of report ___ initial ___ update ___ complete

27C. Date ___/___/___ 28C. Completed by (initials) _____