Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

CASE ID__ __ __ __ --____ -- __ __ __

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 _____ _____ **2A. Date of birth** _____/_____/____
last first mo / day / yr

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

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 <u>first</u> 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 _____ **19A. Phone** (_____)_____
Name City/State

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** (_____)_____

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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/mm^3

54A. Lowest hemoglobin .....g/dL

55A. Lowest hematocrit .....%

56A. Lowest platelet count .....K/mm^3

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)_____

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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_____**

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B B

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 ***26*B. 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) _____**

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C C

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.....**	**☐ yes**	**☐ no**	**☐ unsure**	***if yes***	**5C.** ___/___/___
6C.	**Seizure.....**	**☐ yes**	**☐ no**	**☐ unsure**	***if yes***	**7C.** ___/___/___
8C.	**Paralysis or hemiparesis.....**	**☐ yes**	**☐ no**	**☐ unsure**	***if yes***	**9C.** ___/___/___
10C.	**Blindness.....**	**☐ yes**	**☐ no**	**☐ unsure**	***if yes***	**11C.** ___/___/___
12C.	**Other major neurologic sequelae .....**	**☐ yes**	**☐ no**	**☐ unsure**	***if yes***	**13C.** ___/___/___

***if yes*, Describe:** _____

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 (intials)_____