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CDC's FoodNet Hemolytic Uremic Syndrome (HUS) Surveillance Case Report Form

1A. Case ID	YYYY ^{Year} XX ^{Fipscode} 001 ^{Record}	_____
2A. State ID		_____
3A. FoodNet Person ID (if applicable)		_____
4A. Site		_____
5A. Date entered		_____/_____/_____

Demographic Information

Instructions: Complete the following demographic information as it pertains to the patient diagnosed with HUS.

6A. Date of Birth	_____/_____/_____
7A. State of Residence	_____
8A. County of residence	_____
9A. Sex	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown
10A. Ethnicity	<input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> Unknown
11A. Race	<input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Asian <input type="radio"/> American Indian / Alaska Native <input type="radio"/> Pacific Islander / Native Hawaiian <input type="radio"/> Multi-Racial <input type="radio"/> Other <input type="radio"/> Unknown

Clinical Information

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

12A. Is the date of HUS diagnosis known?	<input type="radio"/> yes <input type="radio"/> no
13A. Date of HUS diagnosis?	_____/_____/_____
14A. Did the patient have diarrhea in the 3 weeks before HUS diagnosis?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unknown
<u>if yes</u> 15A. Date of diarrhea onset	_____/_____/_____
16A. Did stools contain visible blood at the time?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unknown
17A. Was diarrhea treated with antimicrobial medications?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unknown
<u>if yes</u> 18A. Types of antimicrobials used to treat diarrhea: (check all that apply)	
	<input type="checkbox"/> Azithromycin (Zithromax, Z-Pak)
	<input type="checkbox"/> Ceftriaxone (Rocephin)
	<input type="checkbox"/> Ciprofloxacin (Cipro)
	<input type="checkbox"/> Levofloxacin (Levaquin)
	<input type="checkbox"/> Metronidazole (Flagyl)
	<input type="checkbox"/> Piperacillin
	<input type="checkbox"/> Tazobactam
	<input type="checkbox"/> Trimethoprim Sulfamethoxazole (Bactrim, Septra)
	<input type="checkbox"/> Vancomycin (Vancocin)
	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Unknown

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Clinical Information Continued

19A. 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 unknown

20A. Was the patient treated with an antimicrobial medication (ANY antibiotic) for any other reason than diarrhea during the 3 weeks before HUS diagnosis? yes no unknown

if yes 21A. Reason treated with antimicrobial _____

22A. Types of antimicrobials used to treat conditions other than diarrhea: (check all that apply)

- Azithromycin (Zithromax, Z-Pak)
- Ceftriaxone (Rocephin)
- Ciprofloxacin (Cipro)
- Levofloxacin (Levaquin)
- Metronidazole (Flagyl)
- Piperacillin
- Tazobactam
- Trimethoprim Sulfamethoxazole (Bactrim, Septra)
- Vancomycin (Vancocin)
- Other _____
- Unknown

Other medical conditions present during 3 weeks before HUS diagnosis:

23A. Other gastrointestinal illness yes no unknown

24A. Urinary tract infection yes no unknown

25A. Respiratory tract infection yes no unknown

26A. Other acute illness yes no unknown

if yes Describe _____

27A. Pregnancy yes no unknown

28A. Kidney disease yes no unknown

29A. Immune compromising condition or medication yes no unknown

if yes 30A. Malignancy yes no unknown

31A. Transplanted organ or bone marrow yes no unknown

32A. HIV infection yes no unknown

33A. Steroid Use (parenteral or oral) yes no unknown

Other yes no unknown

Describe _____

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

Instructions: Record the correct units or convert to the correct units before entering into the HUS database, especially for platelet count (e.g., enter a platelet count of 33,700/mm³ as 33.7)

34A. Highest serum creatinine _____ mg/dL (suggested range: 0.10-30.00)

35A. Highest serum BUN _____ mg/dL (suggested range: 4.0-100.0)

36A. Highest WBC _____ K/mm³ (suggested range: 0.50-125.00)

A**A****Laboratory Values Continued**

- 37A. Lowest hemoglobin _____ g/dL (suggested range: 2.0-30.0)
- 38A. Lowest hematocrit _____ % (suggested range: 0.0-100.0)
- 39A. Lowest platelet count _____ K/mm³ (suggested range: 3.0-600.0)
- 40A. Microangiopathic changes yes no unknown not tested
- Other laboratory findings within 7 days before and 3 days after HUS diagnosis:
- 41A. Blood (or heme) in urine yes no unknown not tested
- 42A. Protein in urine yes no unknown not tested
- 43A. RBC in urine by microscopy yes no unknown not tested

Epi Information

Instructions for Hospital Discharge Data: All records meeting the ICD9-or ICD10-CM codes specified in the surveillance protocol should be reviewed even if the case had already been identified through Active Surveillance in order to obtain potentially missing information. If a case is captured through HDD and was previously identified through the network of practitioners, sites should check that the abstracted information from active surveillance is current and complete. In the event that additional information is available, this should be included in the FoodNet HUS surveillance system. If a discrepancy is identified, the most current information should be used.

- 44A. 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
 - Report of HUS case by a non-participating physician or service
 - Routine STEC infection active surveillance
 - Retrospective review of hospital discharge data
 - Other (please specify) _____
 - Unknown
- 45A. Date reported to public health or identified by hospital discharge data review _____ / _____ / _____
- 46A. Was hospital discharge data review completed for this case (to verify or supplement information)? yes no unknown
- 47A. Date of HDD (hospital discharge data) review _____ / _____ / _____
- 48A. Is this case epidemiologically linked to a confirmed or probable Shiga toxin-producing *E.coli* (STEC) case? yes no unknown
- 49A. Is this case outbreak related? yes no unknown

Form A Comments, Composite Variables, and Status

- 50A. Completed by (initials): _____
- 51A. Comments _____

- 55A. Complete? incomplete unverified complete

B**B**

**CDC's Foodnet Hemolytic Uremic Syndrome Surveillance
Microbiology Report Form**

Instructions: Enter the most relevant microbiology tests associated with this HUS case by specimen source. If multiple positive stool specimens were tested, prioritize specimens tested by the SPHL or CDC. Include positive stool with any evidence of STEC, and, if applicable, serum sent to CDC for testing of abxbodies against STEC and/or one other positive specimen if additional results are available. In addition, you will be prompted to enter negative results (if applicable) only for evidence of STEC.

Stool Specimen

1B. Was stool collected?

 yes no unknown

2B. Date stool specimen collected

_____/_____/_____

3B. State Lab ID:

Instructions: Answer below questions as they pertain to the stool specimen collected at each lab. You will be asked about other specimens in the other pathogens section.

4B. Questions	Clinical Lab	State or Local PHL	CDC Lab (Federal)
Was this specimen forwarded to the lab?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	N/A
Was testing performed at lab?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk
Was a Shiga toxin test performed? (e.g. PCR, EIA)	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	N/A
Shiga toxin test result	<input type="radio"/> positive <input type="radio"/> negative	<input type="radio"/> positive <input type="radio"/> negative	<input type="radio"/> positive <input type="radio"/> negative
Shiga toxin type	<input type="radio"/> stx1 <input type="radio"/> stx2 <input type="radio"/> stx1 & stx2 <input type="radio"/> undifferentiated	<input type="radio"/> stx1 <input type="radio"/> stx2 <input type="radio"/> stx1 & stx2 <input type="radio"/> undifferentiated	<input type="radio"/> stx1 <input type="radio"/> stx2 <input type="radio"/> stx1 & stx2 <input type="radio"/> undifferentiated
Was a CIDT for <i>E. coli</i> O157 performed? (e.g. Immunocard Stat)	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	N/A
CIDT result?	<input type="radio"/> positive <input type="radio"/> negative	<input type="radio"/> positive <input type="radio"/> negative	N/A
Did the test include H7?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	N/A	N/A
Was a culture for <i>E. coli</i> O157 performed?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	N/A
Was <i>E. coli</i> O157 isolated?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk
Was a culture for <i>E. coli</i> non-O157 performed?	N/A	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	N/A
Was <i>E. coli</i> non-O157 isolated?	N/A	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk
O Antigen	N/A	<input type="radio"/> O26 <input type="radio"/> O111 <input type="radio"/> O103 <input type="radio"/> O121 <input type="radio"/> O45 <input type="radio"/> O145 <input type="radio"/> rough <input type="radio"/> und <input type="radio"/> not found	
H Antigen	<input type="radio"/> H7 pos <input type="radio"/> H7 neg <input type="radio"/> non-motile <input type="radio"/> not tested		

5B. Was immunomagnetic separation (IMS) used to identify common STEC serogroups?

 yes no unknown

6B. What serogroup(s) did the IMS procedure target? (check all that apply)

 O157 O26 O45
 O103 O111 O121
 O145

7B. Was whole genome sequencing (WGS) performed on this isolate? (at state or CDC)

 yes no unknown

8B. Sequencing ID:

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CDC Serology Tests

9B. Has patient serum or plasma been sent to CDC for testing for antibodies to O157 or other STEC? yes no unknown

10B. Date serology specimen collected? _____ / _____ / _____

11B. State laboratory ID for serum _____

12B. Was there more than one serology result for this case? yes no unknown

13B. Questions						
LPS type	Titer IgG	Interpretation of IgG		Titer IgM	Interpretation of IgM	
		Positive	Negative		Positive	Negative
<input type="radio"/> O157 <input type="radio"/> O111						
<input type="radio"/> O157 <input type="radio"/> O111						
<input type="radio"/> O157 <input type="radio"/> O111						

Other Pathogens (co-infections) and Other Specimens

14B. Questions	Clinical Lab	State or Local PHL	CDC Lab (federal)
Were any other pathogens identified?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk
Specimen source	Same stool used for STEC testing	Same stool used for STEC testing	Same stool used for STEC testing
Test type	<input type="radio"/> culture <input type="radio"/> CIDT	<input type="radio"/> culture <input type="radio"/> CIDT	<input type="radio"/> culture <input type="radio"/> CIDT
Pathogen			
Other Specimens (second specimen)			
Was any other specimen collected?	<input type="radio"/> yes <input type="radio"/> no <input type="radio"/> unk		
Date other specimen collection	_____ / _____ / _____		
Specimen source			
Test type 1	<input type="radio"/> culture <input type="radio"/> non-culture (CIDT)		
Pathogen 1			
Test type 2	<input type="radio"/> culture <input type="radio"/> non-culture (CIDT)		
Pathogen 2			
Where positive? (check all that apply)	<input type="checkbox"/> clinic <input type="checkbox"/> State or local <input type="checkbox"/> CDC		
Other specimen State lab id			

Form B Comments, Composite Variables, and Status

15B. Completed by (initials) _____

16B. Comments

20B. Complete? incomplete unverified complete

C**C**

CDC's Foodnet Hemolytic Uremic Syndrome Surveillance 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.*

Hospitals

- 1C. Was patient hospitalized? yes no unknown
- 2C. Date of first admission: _____/_____/_____
- 3C. Date of last discharge: _____/_____/_____

Complications

Did any of the following complications occur during this admission:

- | | | | | | Date of onset |
|--------------------------------------|---------------------------|--------------------------|-------------------------------|---------------|---------------------|
| 4C. Pneumonia | <input type="radio"/> yes | <input type="radio"/> no | <input type="radio"/> unknown | <i>if yes</i> | 5C. ____/____/____ |
| 6C. Seizure | <input type="radio"/> yes | <input type="radio"/> no | <input type="radio"/> unknown | <i>if yes</i> | 7C. ____/____/____ |
| 8C. Paralysis or hemiparesis | <input type="radio"/> yes | <input type="radio"/> no | <input type="radio"/> unknown | <i>if yes</i> | 9C. ____/____/____ |
| 10C. Blindness | <input type="radio"/> yes | <input type="radio"/> no | <input type="radio"/> unknown | <i>if yes</i> | 11C. ____/____/____ |
| 12C. Other major neurologic sequelae | <input type="radio"/> yes | <input type="radio"/> no | <input type="radio"/> unknown | <i>if yes</i> | 13C. ____/____/____ |
- if yes, Describe:* _____

Were any of the following procedures performed during this admission:

- 14C. Peritoneal dialysis yes no unknown
- 15C. Hemodialysis yes no unknown
- Transfusion with:
- 16C. packed RBC or whole blood yes no unknown
- 17C. platelets yes no unknown
- 18C. fresh frozen plasma yes no unknown
- 19C. Plasmapheresis yes no unknown
- 20C. Laparotomy or other abdominal surgery* yes no unknown
 (*other than insertion of dialysis catheter)
if yes Describe: _____

Discharge

- 21C. Condition at discharge dead alive
- if dead* 22C. Date deceased _____/_____/_____
- if alive* 23C. Requiring dialysis yes no unknown
- 24C. With neurologic deficits yes no unknown

Form C Comments, Composite Variables, and Status

- 25C. Completed by (initials): _____
- 26C. Comments _____
- 28C. Complete? incomplete unverified complete