

Shiga toxin Producing E.Coli (STEC)

PATIENT DEMOGRAPHICS

Name (last, first): _____		*Birth date: __/__/____ Age: _____
Address (mailing): _____		*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
Address (physical): _____		*Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
City/State/Zip: _____		*Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer.
Phone (home): _____ Phone (work/cell) : _____		(Mark all that apply) <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Asian <input type="checkbox"/> Unk
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____		

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Case Classification: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
Investigation Start Date: __/__/____	
Earliest date reported to LHD: __/__/____	
Date sent for Regional Review: __/__/____	

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: Laboratory Hospital Private Provider Public Health Agency Other

Reporter Name: _____ Reporter Phone: _____

Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __/__/____	Diagnosis date: __/__/____	Recovery date: __/__/____
Clinical Findings Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloody stool <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever highest temp _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemolytic Uremic Syndrome (HUS) <i>(If developed HUS, then must be reported separately as a case of HUS also)</i>		*Hospitalization Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospitalized for this illness Hospital name: _____ Admit date: __/__/____ Discharge date: __/__/____ *Death Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Died due to this illness Date of death: __/__/____ Predisposing Factors <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Antibiotics taken for this illness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Underlying illness, specify _____

LABORATORY (Please submit copies of all labs associated with this illness to DIDE)

Specimen source: <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> STEC O157:H7 culture <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> STEC non O157:H7 culture Non O157:H7 serotype: _____
Collection date: __/__/____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shiga toxin assay (EIA), ONLY -no isolation of E.coli <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Isolate submitted to state public health lab (OLS)

Notes (clinical/laboratory)

INFECTION TIMELINE

Instructions:

Enter onset date in grey box. Count backward to determine probable exposure period

Days from onset

Calendar dates:

Exposure period

-8 (Max Incubation)	-1 (Min Incubation)
_ / _ / _	_ / _ / _

Onset date



_ / _ / _

EPIDEMIOLOGIC EXPOSURES

Y N U

- *Eat raw or undercooked hamburger, red meat, or pork?
- *Eat or drink raw or unpasteurized milk?
- *Eat unpasteurized dairy products (soft cheese from raw milk, queso fresco, etc.)?
- Eat sprouts (alfalfa, clover, bean)?
- Eat raw fruits or vegetables
- Work with animals or animal products (research, vet, slaughter)?
- Drink untreated/unchlorinated water (i.e. surface, well)?
- *Visit a petting zoo, farm or pet shop? Facility Name: _____
- *Contact with livestock or manure?
- Travel to another state or country? If yes, where _____
- Hike, camp, fish or swim? If yes, where _____

***Is case a member of a high risk occupation?**

(Mark One)

- Food Handler
- Health Care Worker
- Day Care Worker/Attendee
- Student
- None of Above

Employer/School Name: _____

Attend any group activities, parties or gatherings? **Yes / No** If yes, list

Date	Activity	Location

Eat at any restaurant in the last 7 days? **Yes / No** If yes, list

Date	Name of Restaurant	Location

Complete Open-Ended Food History on next page.

Information does not need entered into WVEDSS, however it should be kept with the paper record of the case. State health department staff may request if case is later identified as part of an outbreak.

Food History Completed? Yes / No

PUBLIC HEALTH ISSUES

If any household member is symptomatic, the member is epi-linked and therefore is a probable case and should be investigated further. A stool culture and disease case report should be completed.

Name	Relationship to Case	Onset Date	Lab Testing

Y N NA

- Employed as food handler
 - Non-occupational food handling (e.g. pot lucks, receptions)
 - Attends or employed in child care
 - Household member or close contact in sensitive occupation (food, HCW, child care)
 - Case is part of an outbreak
- Outbreak Name: _____

PUBLIC HEALTH ACTIONS

Y N NA

- Disease/Transmission Education Provided
* Date: _____
- Exclude individuals in sensitive Occupations(food, HCW, child care)
- Restaurant inspection
- Child care inspection
- Culture symptomatic contacts
- Patient is lost to follow up
- Other: _____

Name: _____
 DOB: _____
 Condition: _____ STEC _____

OPEN ENDED FOOD HISTORY

(for Enteric Diseases)

DAY 1 (DATE OF ONSET)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

DAY 2 (1 day before onset)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

DAY 3 (2 days before onset)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

DAY 4 (3 days before onset)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

DAY 5 (4 days before onset)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		