SHIGA TOXIN-PRODUCING *ESCHERICHIA COLI* (STEC) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ unknown ☐ weeks ☐ years

Did the patient die from this illness? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐ No ☐ Unknown ☐ Yes Is this patient a food handler? ☐ No ☐ Unknown ☐ Yes

Is this case part of an outbreak? ☐ No ☐ Unknown ☐ Yes If yes, outbreak name:_____

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments: _____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):_____

SIGNS AND SYMPTOMS

Diarrhea: ☐ No ☐ Unknown ☐ Yes

Abdominal Cramps: ☐ No ☐ Unknown ☐ Yes

PHEP PROJECT

Presumptive diagnosis date: __ __ / __ __ /__ __ __ __

Initial report method: ☐ ELR ☐ E-mail ☐ Fax ☐ Mail ☐ Phone ☐ Other_____

Initial report to Public Health provided by: ☐ ELR ☐ Emergency Room ☐ Infection Preventionist/Hospital ☐ Microbiologist/Hospital ☐ Patient ☐ Physician/Practitioner ☐ Other_____

Control Measures:

Date control measures implemented: __ __ / __ __ /__ __ __ __

Education of case/contacts: ☐ No ☐ Unknown ☐ Yes

Exclusion from food handling: ☐ No ☐ Unknown ☐ Yes

Exclusion from healthcare: ☐ No ☐ Unknown ☐ Yes

Exclusion from daycare/school: ☐ No ☐ Unknown ☐ Yes

Identification of exposed individuals: ☐ No ☐ Unknown ☐ Yes

Identification of additional cases: ☐ No ☐ Unknown ☐ Yes

Identification of possible source of infection: ☐ No ☐ Unknown ☐ Yes

Collection of food: ☐ No ☐ Unknown ☐ Yes

Other measure: _____

DAY CARE

Attend a day care center? ☐ No ☐ Unknown ☐ Yes

Work at a day care center? ☐ No ☐ Unknown ☐ Yes

Live with a day care center attendee? ☐ No ☐ Unknown ☐ Yes

What is the name of the day care facility? _____

What type of day care facility: ☐ Adult day health care ☐ Adult day social care ☐ Alzheimer's specific day care ☐ Child care center ☐ Child care provided by friend, relative, neighbor ☐ In-home care giver

Is food prepared at this facility? ☐ No ☐ Unknown ☐ Yes

Does this facility care for diapered persons? ☐ No ☐ Unknown ☐ Yes

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐ No ☐ Unknown ☐ Yes

Applicable incubation period for this illness is: **10 days**

What was the purpose of travel? ☐ Business ☐ Migration (immigration to US) ☐ Other _____ ☐ Tourism ☐ Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐ Do not use tap water ☐ Municipal, city, or county ☐ Other_____ ☐ Private well ☐ Unknown

If "Private Well", how was home well water treated?

☐ Both filtered and disinfected ☐ Disinfected ☐ Filtered ☐ Neither filtered nor disinfected ☐ Unknown

What is the source of tap water at school/work? ☐ Do not use tap water ☐ Municipal, city, or county ☐ Other_____ ☐ Private well ☐ Unknown

If "Private Well", how was school/work well water treated?

☐ Both filtered and disinfected ☐ Disinfected ☐ Filtered ☐ Neither filtered nor disinfected ☐ Unknown

Did the patient drink untreated water in the **10 days** prior to onset of illness (e.g., from a river while camping)? ☐ No ☐ Unknown ☐ Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **10 days** prior to illness? ☐ No ☐ Unknown ☐ Yes

What was the recreational water exposure type? (select all that apply)

☐ Hot Spring ☐ Hot Tub-Whirlpool-Jacuzzi-Spa ☐ Interactive Fountain ☐ Lake-Pond-River-Stream

☐ Ocean ☐ Other _____ ☐ Recreational Water Park ☐ Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐ Camp Pool ☐ Hospital/Therapy Pool ☐ Hotel/Motel/Resort Vacation Pool

☐ Kiddie/Wading Pool ☐ Municipal/Community Pool ☐ Neighborhood/subdivision/Apartment/Condo Pool

☐ Other, specify_____ ☐ Private Club/Membership Pool ☐ Private Home Pool, not a kiddie/wading pool

☐ School/College/University Pool ☐ Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **10 days** prior to onset of illness? ☐ No ☐ Unknown ☐ Yes

If yes, select type of animal: ☐ Cat ☐ Cattle ☐ Chicken ☐ Dog ☐ Goats ☐ Lizard
☐ Poultry ☐ Rodent ☐ Sheep ☐ Swine ☐ Turtle ☐ Unknown
☐ Other, specify: _____

Name or location of animal contact: _____

Did a patient come into contact with animal food/feed(s) in the **10 days** prior to onset of illness? ☐ No ☐ Unknown ☐ Yes

If yes, select associated animal food/feed(s): ☐ Cat ☐ Cattle ☐ Chicken ☐ Dog ☐ Goats ☐ Lizard
☐ Poultry ☐ Rodent ☐ Sheep ☐ Swine ☐ Turtle ☐ Unknown
☐ Other, specify: _____

If applicable, please list food brand(s): _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐ CSF leak
☐ Alcohol abuse
☐ Burns
☐ Cirrhosis/liver failure
☐ Deaf/profound hearing loss
☐ Gastric surgery (type): _____
☐ Immunodeficiency (type): _____
☐ Leukemia
☐ None
☐ Other malignancy (type): _____
☐ Peptic ulcer
☐ Splenectomy/asplenia
☐ Hodgkin's disease
☐ Asthma
☐ Cerebral vascular accident (CVA) stroke
☐ Cochlear implant
☐ Diabetes mellitus (insulin):☐No ☐Unk ☐Yes
☐ Heart failure
☐ Immunoglobulin deficiency
☐ Multiple myeloma
☐ Organ transplant (organ): _____
☐ Other prior illness (type): _____
☐ Renal failure/dialysis
☐ Systemic lupus erythematosus (SLE)
☐ IVDU
☐ Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐ Chronic GI illness/diarrhea
☐ Current smoker
☐ Emphysema/COPD
☐ Hematologic disease (type): _____
☐ Immunosuppressive therapy (steroids, chemotherapy)
☐ Nephrotic Syndrome
☐ Other liver disease (type): _____
☐ Other renal disease (type): _____
☐ Sickle cell anemia
☐ Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐ No ☐ Unknown ☐ Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐ No ☐ Unknown ☐ Yes

Are the other cases related to this one? ☐ No, sporadic ☐ Unknown ☐ Yes, household ☐ Yes, not household ☐ Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the ALNBS Investigation.

CASE CLASSIFICATION		
1	Was *Escherichia coli* O157:H7 or Shiga toxin-producing *E. coli* isolated from any clinical specimen?	☐ No ☐ Unknown ☐ Yes
2	Was *E.c oli* O157 isolated from any clinical specimen, without confirmation of H antigen or Shiga toxin production?	☐ No ☐ Unknown ☐ Yes
3	Is the patient symptomatic with diarrhea and abdominal cramps and epidemiologically linked to a confirmed case?	☐ No ☐ Unknown ☐ Yes
4	Is the patient symptomatic with diarrhea and abdominal cramps with an elevated antibody titer to a known Shiga toxin-producing *E. coli* serotype?	☐ No ☐ Unknown ☐ Yes
5	Is the patient symptomatic with diarrhea and abdominal cramps with Shiga toxin identified without isolation of the Shiga toxin-producing *E. coli*?	☐ No ☐ Unknown ☐ Yes
6	Is the patient a case of postdiarrheal HUS or TTP?	☐ No ☐ Unknown ☐ Yes
Confirmed: 1	**Probable: 2 or 3 or 4**	**Suspect: 5 or 6**