

E. Coli O157:H7 and other Shiga-Toxin producing strains

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case

Reviewer initials: _____
Referred to another state: _____

CASE

Last name: _____
First and middle name: _____
Maiden name: _____ Suffix: _____
Address line: _____
Zip: _____ City: _____
State: _____ County: _____
Phone: ()- - Type: _____
Long-term care resident: Yes No Unknown
Facility name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____
Gender: Female Male Other _____
Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____
Marital status: Single Married Divorced Parent with partner Separated Widowed
Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian
Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
Parent/Guardian name: _____
Parent/Guardian phone: ()- - Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____
Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown
Date of Death: ____ / ____ / ____
Event exception: Case could not be found
 Case could not be interviewed
 Case refused interview
 Other – see notes
Outbreak related: Yes No Unknown
Outbreak name: _____
Exposure setting: _____
Epi-linked: Yes No Unk To whom: _____
Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown
State: _____ Country: _____

Healthcare provider information

Last name: _____
First name: _____
Provider title: ARNP MD PA
 DO NP
Facility name: _____
Address line 1: _____
Address line 2: _____
Zip code: _____ City: _____
State: _____ County: _____
Phone : ()- - Type: _____

LABORATORY FINDINGS

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____
Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative
Organism: **E. coli** Serotype: _____

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____
Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative
Organism: **E. coli** Serotype: _____

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: E. coli	Serotype: _____	

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
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Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____) - ____ - ____ Type: _____
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Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____
Days hospitalized: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
	Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____

CLINICAL INFO & DIAGNOSIS

HUS	TTP
Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Onset Date ____ / ____ / ____	Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Onset Date ____ / ____ / ____

If HUS or TTP diagnosis create new HUS event for this case

Symptoms	Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours	Visible bloody diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours
	Nausea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours	Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours
	Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours	Highest known fever: _____ °F <input type="checkbox"/> °C
	Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours	Abdominal cramps <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours
	Muscle weakness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours	Chills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk _____ Days/Hours
	First symptom: _____	Most severe symptom: _____
		Date returned to normal activities: ____ / ____ / ____

OTHER LAB FINDINGS

Clinical specimen from case

Was PFGE performed: Yes No Unk

IA-Xbal Pattern		IA-Blnl Pattern		CDC-Xbal Pattern		CDC-Blnl Pattern	
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Environmental specimen testing

Food, Medication, or environmental samples tested? Yes No Unk Describe samples: _____ (circle positives)

For what were the samples tested? E. coli or EHEC Salmonella Shigella Other testing (specify): _____

Laboratory: _____ Positive? Yes No Unk PFGE performed? Yes No Unk

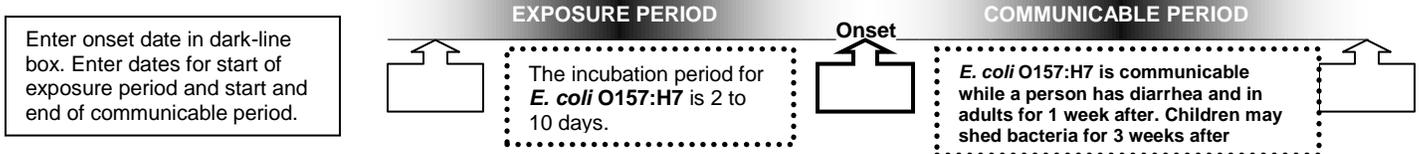
IA-Xbal Pattern		IA-Blnl Pattern		CDC-Xbal Pattern		CDC-Blnl Pattern	
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TREATMENT

Antibiotics prescribed? Yes No Unknown

Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____
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INFECTION TIMELINE



RISK FACTORS/TRAVEL

Risk Factors/Travel Information – In the 10 days prior to onset of symptoms did the case:

Travel	Travel within Iowa? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk City in Iowa: _____	Departure date: ____/____/____	Return date: ____/____/____
	Travel within U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk State: _____ City: _____	Departure date: ____/____/____	Return date: ____/____/____
	Travel outside U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Country: _____	Departure date: ____/____/____	Return date: ____/____/____

Visit restaurants? Yes No Unknown

If Yes, complete the table below:

County and address are missing from this table

Establishment name	Address/Zip	Date visited	Foods consumed	Others ill?
		____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Attend Group Gatherings (e.g. weddings, parties)? Yes No Unknown

If Yes, complete the following table:

Location name	Address/Zip	Date visited	Foods consumed	Others ill?
		____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Where did the case purchase groceries in the 2 weeks before the onset of symptoms:

Store name	Address	City/State/Zip	County	Date purchased
				/ /
				/ /
				/ /

Dietary Information – In the 10 days prior to onset of symptoms did the case consume the following:

Meat and poultry

Any of these meat products? Poultry Ground beef Pork Meat other than ground meat (salami, jerky, wild game)

Where was grilling done? At own home Another person's home Picnic Vendor stand

Other; Please list: _____

From dates consumed: / / , / / To dates consumed: / / , / /

Was the meat fully cooked? Yes No Unknown

List all source/types: _____

List all brand names: _____

From dates consumed: / / , / / To dates consumed: / / , / /

Other meat and poultry products

Deii/lunch meat Yes No Unk From dates consumed: / / To dates consumed: / /

List all source/types: _____ List all brand names: _____

Raw/partially cooked eggs or in foods (e.g. cookie dough): Yes No Unk

From dates consumed: / / To dates consumed: / /

List all source/types: _____ List all brand names: _____

Unpasteurized products

Unpasteurized milk: Yes No Unk From dates consumed: / / To dates consumed: / /

List all source/types: _____ List all brand names: _____

Unpasteurized juice: Yes No Unk From dates consumed: / / To dates consumed: / /

List all source/types: _____ List all brand names: _____

Other unpasteurized products: Yes No Unk From dates consumed: / / To dates consumed: / /

List all source/types: _____ List all brand names: _____

Other products

Health supplements: Yes No Unk From date consumed: / / To dates consumed: / /

List all source/types: _____ List all brand names: _____

Infant formula: Yes No Unk From date consumed: / / To dates consumed: / /

List all source/types: _____ List all brand names: _____

Baby food: Yes No Unk From date consumed: / / To dates consumed: / /

List all source/types: _____ List all brand names: _____

Fruits and vegetables

Raw fruits: Yes No Unk From dates consumed: ____ / ____ / ____ To dates consumed: ____ / ____ / ____

List all source/types: _____ List all brand names: _____

Raw vegetables: Yes No Unk From dates consumed: ____ / ____ / ____ To dates consumed: ____ / ____ / ____

List all source/types: _____ List all brand names: _____

Other

Leftover foods consumed: Yes No Unk Reheated: Yes No Unk From date consumed: ____ / ____ / ____ To date consumed: ____ / ____ / ____

Describe leftovers consumed: _____

Animal Exposures – In the 10 days prior to the onset of symptoms did the case:

Check all that apply

Visit or live on a farm: Yes No Unknown
Exposed to manure: Yes No Unknown
Have farm animal contact: Yes No Unknown Animals: _____

Have reptile contact: Yes No Unknown Iguana Lizard Turtle Snake Other _____
Reptile lived with case: Yes No Unknown

Have other animal contact in home: Yes No Unknown Animal: _____ Animal sick: Yes No Unk

Visit a petting zoo: Yes No Unknown Touched animals: Yes No Unk Animal: _____

Zoo name: _____ **Address/Zip/County:** _____

Water Exposures – In the 10 days prior to the onset of symptoms did the case

Go swimming? Yes No Unknown

If Yes, complete the table below:

Water Type	Location Type	Dates visited	Facility name / Street address & Zip
<input type="checkbox"/> Hot tub/spa <input type="checkbox"/> Pond	<input type="checkbox"/> Hotel/motel	From ____ / ____ / ____	_____
<input type="checkbox"/> Kiddie pool <input type="checkbox"/> Water park	<input type="checkbox"/> Indoor private	To ____ / ____ / ____	
<input type="checkbox"/> River/stream <input type="checkbox"/> Swimming pool	<input type="checkbox"/> Indoor public		
<input type="checkbox"/> Lake <input type="checkbox"/> Water fountain/ splash pad	<input type="checkbox"/> Outdoor private		
<input type="checkbox"/> Other _____	<input type="checkbox"/> Outdoor public		

Drinking water supply

Home: Bottled Municipal Well Commercial Delivery Rural water

Work: Bottled Municipal Well Commercial Delivery Rural water

School: Bottled Municipal Well Commercial Delivery Rural water

Child care: Bottled Municipal Well Commercial Delivery Rural water

Other Exposures – In the 10 days prior to the onset of symptoms did the case:

Wear diapers: Yes No Unk **Have contact with diapers:** Yes No Unk

Have contact with immunocompromised person: Yes No Unk Setting: Home Work Other _____

Have sex with someone with similar symptoms: Yes No Unk Sexual preference: Hetero Homo Bisexual Unknown

CONTACTS

Number of people living in case's household: _____

Are there close contacts of the case with same symptoms: Yes No Unknown

Close contacts of the case with the same symptoms

Name	DOB	Gender	Address/Phone	
_____	____ / ____ / ____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	
		Zip code: _____	Phone: _____ - _____ - _____	
Relationship to case	List symptoms	Symptom onset date	Same exposures	Is contact a case?
<input type="checkbox"/> Spouse <input type="checkbox"/> Sexual contact	<input type="checkbox"/> Family member (non-household)	____ / ____ / ____	<input type="checkbox"/> Restaurant <input type="checkbox"/> Gatherings	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Friend/acquaintance	<input type="checkbox"/> Contact- work/school/etc	_____	<input type="checkbox"/> Food <input type="checkbox"/> Animal	
<input type="checkbox"/> Sibling <input type="checkbox"/> Unknown/Other			<input type="checkbox"/> Water	
<input type="checkbox"/> Roommate				
<input type="checkbox"/> Parent/ guardian				

If this contact is a case create a new event and/or case for this contact. ←

