Hemolytic Uremic Syndrome (HUS)

Investigator: _____ **Agency:** _____ **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 ☐ Separated ☐ Divorced ☐ Parent with partner ☐ 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
Date of Death __/__/__ ☐ Unknown
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: _____
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: Serotype:

Laboratory: _____ Accession #: _____ Collection date: __/__/__
Date received: __/__/__ Specimen source: _____ Test type: _____
Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative
Organism: Serotype:

Laboratory: _____ Accession #: _____ Collection date: __/__/__

Date received: / / Specimen source: Test type:

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Serotype:

OCCUPATIONS

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

Occupation type: Job title:

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name:

Date worked from: / / Address:

Date worked to: / / Zip code:

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: State: County:

Date removed: / / Phone: ( )- - Ext: Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Occupation type: Job title:

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name:

Date worked from: / / Address:

Date worked to: / / Zip code:

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: State: County:

Date removed: / / Phone: ( )- - Ext: Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: Admission date: / / Discharge date: / /

Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry):

Days hospitalized: Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Developed anemia: ☐ Yes ☐ No ☐ Unknown

Microangiopathic changes present: (schistocytes, burr cells, or helmet cells on peripheral blood smear) ☐ Yes ☐ No ☐ Unknown

Antacids taken: ☐ Yes ☐ No ☐ Unknown

TTP Diagnosis ☐ Yes ☐ No ☐ Unk Onset Date / /

Diarrhea within 3 weeks of onset of HUS: ☐ Yes ☐ No ☐ Unk

Clinical indicators: ☐ Elevated creatine level ☐ Proteinuria ☐ Hematuria

Brand Name:

Symptoms

Diarrhea	☐ Yes ☐ No ☐ Unk	____ Days/Hours	Abdominal cramps	☐ Yes ☐ No ☐ Unk	____ Days/Hours
Nausea	☐ Yes ☐ No ☐ Unk	____ Days/Hours	Chills	☐ Yes ☐ No ☐ Unk	____ Days/Hours
Vomiting	☐ Yes ☐ No ☐ Unk	____ Days/Hours	Fever	☐ Yes ☐ No ☐ Unk	____ Days/Hours
Headache	☐ Yes ☐ No ☐ Unk	____ Days/Hours	Visible bloody diarrhea	☐ Yes ☐ No ☐ Unk	____ Days/Hours
Muscle weakness	☐ Yes ☐ No ☐ Unk	____ Days/Hours			

First symptom: Most severe symptom: Date returned to normal activities: / /

OTHER LAB FINDINGS

Food, Medication, or environmental samples tested? ☐ Yes ☐ No ☐ Unk

Describe samples: _____

For what were the samples tested ? ☐ E. coli or EHEC ☐ Salmonella ☐ Shigella

Laboratory: _____

Positive? ☐ Yes ☐ No ☐ Unk

PFGE performed? ☐ Yes ☐ No ☐ Unk

PFGE Pattern:

IAX Pattern		JXB Pattern		XbaI-Pattern		BInI-Pattern	

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic: _____ Date started: / /

Dose: _____ Unit: ☐ mg ☐ ml ☐ IU # of days: _____

# of times a day: _____ Route: _____

Antibiotic: _____ Date started: / /

Dose: _____ Unit: ☐ mg ☐ ml ☐ IU # of days: _____

# of times a day: _____ Route: _____

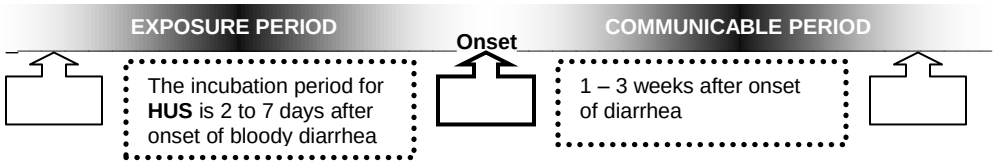
Antibiotic: _____ Date started: / /

Dose: _____ Unit: ☐ mg ☐ ml ☐ IU # of days: _____

# of times a day: _____ Route: _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL *(include 10 days before onset of diarrhea)*

Travel within Iowa? ☐ Yes ☐ No ☐ Unk City in Iowa: _____ Departure date: / / Return date: / /

Travel within U.S.? ☐ Yes ☐ No ☐ Unk State: _____ City: _____ Departure date: / / Return date: / /

Travel outside U.S.? ☐ Yes ☐ No ☐ Unk Country: _____ Departure date: / / Return date: / /

Restaurants visited? ☐ Yes ☐ No ☐ Unknown *If Yes, complete the table below:*

Restaurant	Adress/Zip	Date visited	Foods eaten	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Attended Group Gatherings? ☐ Yes ☐ No ☐ Unknown *If Yes, complete the following table:*

Type of gathering	Address/Zip	Date visited	Foods consumed	Foods prepared	Others ill?
		/ /			☐ Yes ☐ No ☐ Unk
		/ /			☐ Yes ☐ No ☐ Unk
		/ /			☐ Yes ☐ No ☐ Unk

Dietary Information – *In the 10 days prior to onset of diarrheal symptoms did the case:*

Purchase food products? ☐ Yes ☐ No ☐ Unknown *If Yes, complete the table below:*

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

Meat and poultry

Were any of the following consumed? ☐ Poultry ☐ Ground meat ☐ Meat other than ground meat:

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

Deli/luncheon meat ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Raw/partially cooked eggs: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Unpasturized 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: / /

Animal Exposures – *In the 10 days prior to the onset of diarrhea*

Check all that apply

Visit or live on a farm: ☐ Yes ☐ No ☐ Unknown

Exposed to manure: ☐ Yes ☐ No ☐ Unknown

Farm animal contact: ☐ Yes ☐ No ☐ Unknown Animals:

Reptile contact: ☐ Yes ☐ No ☐ Unknown ☐ Iguana ☐ Lizard ☐ Turtle ☐ Other _____

Reptile lived with case: ☐ Yes ☐ No ☐ Unknown

Other animal contact in home: ☐ Yes ☐ No ☐ Unknown Animal: Animal sick: ☐ Yes ☐ No ☐ Unk

Visited 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 diarrhea*

Went swimming? ☐ Yes ☐ No ☐ Unknown *If Yes, complete the table below:*

Type	Location Type	Date visited	Facility name/ Street address & Zip
☐ Hot tub/spa ☐ Pond ☐ Kiddie pool ☐ Water park ☐ River/stream ☐ Swimming pool ☐ Lake ☐ Water fountain/ splash pad ☐ Other_____	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	___/___/___	

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 diarrhea did the case:***

Wear diapers: ☐ Yes ☐ No ☐ Unk

Have contact with diapers: ☐ Yes ☐ No ☐ Unknown

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

Participate in outdoor activities: ☐ Yes ☐ No ☐ Unk

Activities: ☐ Camping ☐ Canoeing ☐ Fishing ☐ Hiking ☐ Hunting ☐ Rafting ☐ Trapping

CONTACTS

Number of people living in case's household: _____

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

Name	DOB	Gender	Address/Phone
	___/___/___	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case	List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Sexual contact ☐ Child ☐ Family member (non-household) ☐ Sibling ☐ Friend/acquaintance ☐ Roommate ☐ Contact- work/school/etc ☐ Parent/ guardian ☐ Unknown/Other		___/___/___	☐ Yes ☐ No

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

Name	DOB	Gender	Address/Phone
	___/___/___	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case	List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Sexual contact ☐ Child ☐ Family member (non-household) ☐ Sibling ☐ Friend/acquaintance ☐ Roommate ☐ Contact- work/school/etc ☐ Parent/ guardian ☐ Unknown/Other		___/___/___	☐ Yes ☐ No

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

Name	DOB	Gender	Address/Phone
	___/___/___	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case	List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Sexual contact ☐ Child ☐ Family member (non-household) ☐ Sibling ☐ Friend/acquaintance ☐ Roommate ☐ Contact- work/school/etc ☐ Parent/ guardian ☐ Unknown/Other		___/___/___	☐ Yes ☐ No

NOTES: _____