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 ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ 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
City and 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: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ 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: ☐ 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 due to this illness: / / Phone: ( )- - 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:

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 due to this illness: / / Phone: ( )- - 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

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

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

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

Symptoms

Diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Nausea ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Vomiting ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Headache ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Muscle weakness ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Visible bloody diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Fever ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Highest known fever: _____ ☐ °F ☐ °C

Abdominal cramps ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Chills ☐ Yes ☐ No ☐ 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-XbaI Pattern		IA-BlnI Pattern		CDC-XbaI Pattern		CDC-BlnI Pattern	

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-XbaI Pattern		IA-BlnI Pattern		CDC-XbaI Pattern		CDC-BlnI Pattern	

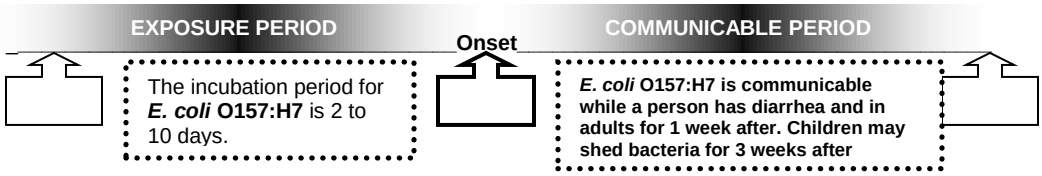
TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:	Antibiotic:	Antibiotic:
Date started: / /	Date started: / /	Date started: / /
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of days:	# of days:	# of days:
# of times a day:	# of times a day:	# of times a day:
Route:	Route:	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

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

Travel

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: / /

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?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ 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?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ 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

Deli/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
☐ 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	From / / To / /	

Drinking water supply

Home:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**School:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well
Work:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**Child care:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well

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
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

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

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

NOTES: