



Shiga toxin-producing *E. coli*

LHJ Use ID _____
 Reported to DOH Date ___/___/___
 LHJ Classification Confirmed
 Probable
 Suspect
 By: Lab Clinical Epi Link

Outbreak-related
 LHJ Cluster# _____
 LHJ Cluster Name: _____
 DOH Outbreak # _____

County _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No DK Date of interview ___/___/___

Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____ Zip
 code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk

CLINICAL INFORMATION

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y N DK NA
 Diarrhea Maximum # of stools in 24 hours: _____
 Bloody diarrhea
 Abdominal cramps or pain
 Nausea
 Vomiting
 Fever Highest measured temp (°F): _____
 Oral Rectal Other: _____ Unk

Hospitalization

Y N DK NA
 Hospitalized at least overnight for this illness
 Hospital name _____
 Admit date ___/___/___ Discharge date ___/___/___
 Y N DK NA
 Died from illness Death date ___/___/___
 Autopsy Place of death _____

Laboratory

Collection date ___/___/___
 Source _____

P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

Predisposing Conditions

Y N DK NA
 Antibiotic taken for this diarrheal illness
 Underlying illness, specify: _____

P N I O NT

***E. coli* O157:H7 culture**
 Non-O157:H7 Shiga toxin+ *E. coli* culture
 Type if non-O157:H7 _____
 ***E. coli* O157 (no H type) Shiga toxin+ culture**
 ***E. coli* O157 (no H type) culture, without Shiga toxin+ [Probable]**
 EHEC titer elevated Type: _____
[Probable]
 Shiga toxin assay, no isolation of *E. coli*
[Suspect]
 Food specimen culture

Clinical Findings

Y N DK NA
 Hemolytic uremic syndrome (HUS)
 Thrombotic thrombocytopenic purpura (TTP)
 Coagulopathy (platelets < 100,000)
 Acute anemia with microangiopathic changes
 Kidney (renal) abnormality or failure
 Kidney dialysis as result of illness

Notes

<i>Washington State Department of Health</i>	Case Name: _____						
INFECTION TIMELINE: All questions refer to the 1 – 8 days before onset.							
Days from onset:	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Exposure period</td> <td style="text-align: center;">Contagious period</td> </tr> <tr> <td style="text-align: center;">-8 days -1 days Onset</td> <td style="text-align: center;">(weeks)</td> </tr> <tr> <td style="text-align: center;">Calendar dates:</td> <td style="text-align: center;">_____</td> </tr> </table>	Exposure period	Contagious period	-8 days -1 days Onset	(weeks)	Calendar dates:	_____
Exposure period	Contagious period						
-8 days -1 days Onset	(weeks)						
Calendar dates:	_____						

EXPOSURES

Enter Data in PHIMS	Hard Copy Only
EXPOSURE (Refer to dates above) Case knows anyone with similar symptoms <input type="checkbox"/> household contact <input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> other attendees at common event <input type="checkbox"/> Other, specify _____	Details:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with lab confirmed case: <input type="checkbox"/> Household <input type="checkbox"/> Casual <input type="checkbox"/> Sexual <input type="checkbox"/> Needle use <input type="checkbox"/> Other: _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologic link to a confirmed human case	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with diapered or incontinent child or adult	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visited, lived or worked in a residential facility	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Were you on any kind of special or restricted diet for medical, weight loss, religious or other reasons?	If yes, describe:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Known contaminated food product? Specify: _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Do you try to select mostly organic products? <input type="checkbox"/> Produce <input type="checkbox"/> Other products	

Sources of food – Hard Copy Only

Sources of food: (<i>check all that apply</i>)	List Store/Retail Names & Locations:
<input type="checkbox"/> Grocery store or supermarkets <input type="checkbox"/> Warehouse stores (e.g., Costco, Sam's Club) <input type="checkbox"/> Small markets, mini marts & convenience stores <input type="checkbox"/> Ethnic specialty markets (Mexican, Asian or Indian) <input type="checkbox"/> Health food stores or Co-ops <input type="checkbox"/> Fish or meat specialty shops (butcher's shop, etc.) <input type="checkbox"/> Farmer's markets, roadside stands, open-air markets, or food purchased directly from a farm <input type="checkbox"/> School or other institutional setting <input type="checkbox"/> Other, specify: _____	

Y N DK NA

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Restaurants - Name(s)/location(s): <i>Note: Add meal details below (hard copy); names/locations should be entered in PHIMS.</i>	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Group meal, (e.g., potluck, reception)	

Foods consumed outside the home (including restaurants, schools, etc.) – Hard Copy Only

Date/Time of Meal	Restaurant/School/Facility Name & Location	Meal description

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	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

Enter Data in PHIMS

Hard Copy Only

Meat

Y N DK NA

Handled any raw red meat, even if you did not eat it?

- Type: Ground beef Steak Stew
 Roast Lamb Goat
 Venison Other

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____
 If steak, type/cut: _____

Did you eat any **ground** beef?

- Rare, undercooked, or raw?** Y N Unk
- Any ground beef at home? Y N Unk
- In what form(s) was the beef purchased?
 Bulk Patties Other Unk

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____
 Size of package purchased: _____ Lbs Unk
 Type of beef purchased: _____ % lean Unk
 Organic: Y N Unk
 How was beef purchased? fresh frozen Unk
 If frozen, how did you thaw the beef?
 counter microwave refrigerator Unk

Any ground beef outside your home? Y N Unk

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____
 If steak, type/cut: _____
Purchase information:

Did you eat any **intact** beef (e.g., steaks, stews, roasts or similar)?

- Type: Steak Stew Roast Other
- Rare, undercooked, or raw? Y N Unk
- Ate steak outside the home? Y N Unk

Details:

Details:

Details:

Wild game meat

- Type: Buffalo/Bison Venison Elk Boar Other

Did you eat jerky or any dry/semi-dry ready-to-eat sausage such as salami, pepperoni or summer sausage (thuringer, mortadella, etc).

Other meat products? Specify _____

Raw/Unpasteurized Products

Y N DK NA

Raw milk

- Type: Cow Goat Other, specify _____

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____
 Is there product remaining? Y N Unk

Cheese made from raw milk

- Type: Queso fresco Queso blanco
 Other, specify _____

Purchase information:
 Facility and location: _____
 Brand: _____ Date bought: _____

Artisanal or gourmet cheese

- Type: _____

Purchase information:
 Facility and location: _____
 Brand: _____ Date bought: _____

Unpasteurized juice or cider

- Type: _____

Purchase information:
 Facility and location: _____
 Brand: _____ Date bought: _____

Other unpasteurized product?

- Type: Kefir Ice cream Other, specify _____

Purchase information:
 Facility and location: _____
 Brand: _____ Date bought: _____

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Enter Data in PHIMS	Hard Copy Only
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Fruit											
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Leafy Greens	
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Vegetables					
Y	N	DK	NA	Sprouts • Type: <input type="checkbox"/> Alfalfa <input type="checkbox"/> Clover <input type="checkbox"/> Bean <input type="checkbox"/> Broccoli <input type="checkbox"/> Daikon radish <input type="checkbox"/> Other, specify _____	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fresh herbs • Type: <input type="checkbox"/> Basil <input type="checkbox"/> Cilantro <input type="checkbox"/> Parsley <input type="checkbox"/> Sage <input type="checkbox"/> Thyme <input type="checkbox"/> Dill <input type="checkbox"/> Other, specify _____	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other fresh vegetables • Specify: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other frozen vegetables • Specify: _____	<i>Details</i>

Water					
Y	N	DK	NA	Source of drinking water known • Type: <input type="checkbox"/> Individual well <input type="checkbox"/> Shared well <input type="checkbox"/> Public water system <input type="checkbox"/> Bottled water <input type="checkbox"/> Other: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drank untreated/unchlorinated water (e.g. surface, well)	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational water exposure • Type: <input type="checkbox"/> Natural water <input type="checkbox"/> Pools, spas, fountain, water park <input type="checkbox"/> Both <input type="checkbox"/> Other: _____ • Name/Location: _____ • Treatment: <input type="checkbox"/> Treated <input type="checkbox"/> Untreated <input type="checkbox"/> Both <input type="checkbox"/> Unknown	<i>Details</i>

Animal Contact					
Y	N	DK	NA	Any contact with animals? • Type: <input type="checkbox"/> Cow/calf <input type="checkbox"/> Goat <input type="checkbox"/> Sheep <input type="checkbox"/> Deer <input type="checkbox"/> Horse/pony <input type="checkbox"/> Donkey <input type="checkbox"/> Live poultry <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other, _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Visit or work at any of the following locations, even if no direct animal contact? <input type="checkbox"/> Live on farm <input type="checkbox"/> Dairy farm <input type="checkbox"/> Other farm <input type="checkbox"/> Veterinary facility <input type="checkbox"/> Slaughter house <input type="checkbox"/> Research facility <input type="checkbox"/> Zoo <input type="checkbox"/> Petting zoo <input type="checkbox"/> 4-H event <input type="checkbox"/> Fair <input type="checkbox"/> Animal show/display <input type="checkbox"/> Pet shop <input type="checkbox"/> Hunting/butchering <input type="checkbox"/> Other _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household member works with animals • Specify: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raw pet food / treats	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apply compost/manure	

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Calendar dates:	_____						

Summary of exposures	
<p>How was this person likely exposed to the disease:</p> <input type="checkbox"/> Food <input type="checkbox"/> Drinking Water <input type="checkbox"/> Recreational water <input type="checkbox"/> Person <input type="checkbox"/> Animal <input type="checkbox"/> Environment <input type="checkbox"/> Unknown	<p>Exposure details (e.g., exposure date, specific site, purchase or use-by date, product name/description):</p> <p>_____</p> <p><input type="checkbox"/> No risk factors or exposures could be identified</p> <p><input type="checkbox"/> Patient could not be interviewed</p>
<p>Where did exposure probably occur?</p> <input type="checkbox"/> U.S. but not WA (State: _____) <input type="checkbox"/> In WA (County: _____) <input type="checkbox"/> Not in U.S. (Country/Region: _____) <input type="checkbox"/> Unknown	

PUBLIC HEALTH ISSUES	PUBLIC HEALTH ACTIONS
<p>Y N DK NA</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed as food worker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Non-occupational food handling (e.g. potlucks, receptions) during contagious period <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed as health care worker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed in child care or preschool <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Attends child care or preschool <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Household member or close contact in sensitive occupation or setting (HCW, child care, food)	<input type="checkbox"/> Exclude from sensitive occupation (HCW, food worker, child care) or situations (child care) until 2 negative stools <input type="checkbox"/> Hygiene education provided Date: ___/___/___ <input type="checkbox"/> Restaurant inspection <input type="checkbox"/> Child care inspection <input type="checkbox"/> Testing of home/other water supply <input type="checkbox"/> Initiate traceback investigation <input type="checkbox"/> Other, specify: _____

NOTES

Investigator _____ Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____	Record complete date ___/___/___