WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

# Shiga toxin Producing E.Coli (STEC)

## PATIENT DEMOGRAPHICS

**Name** (last, first): _____
**Address** (mailing): _____
**Address** (physical): _____
**City/State/Zip**: _____
**Phone** (home): _____ **Phone** (work/cell) : _____

***Alternate contact***: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:* _____ *Phone:* _____

***Birth date**: __ / __ / ____ **Age**: _____
***Sex**: ☐Male ☐Female ☐Unk

***Ethnicity**: ☐Not Hispanic or Latino
☐Hispanic or Latino ☐Unk

***Race**: (Mark all that apply)
☐ White ☐Black/Afr. Amer.
☐ Native HI/Other PI
☐ Am. Ind/AK Native
☐ Asian ☐ Unk

## INVESTIGATION SUMMARY

**Local Health Department** (Jurisdiction): _____
**Investigation Start Date**: __ / __ / ____
**Earliest date reported to LHD**: __ / __ / ____
**Date sent for Regional Review**: __ / __ / ____

**Case Classification**:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

## REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐Private Provider ☐Public Health Agency ☐Other
Reporter Name: _____ Reporter Phone: _____
Primary HCP Name: _____ Primary HCP Phone: _____

## CLINICAL

**Onset date**: __ / __ / ____ **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

### Clinical Findings

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Diarrhea |
| ☐ | ☐ | ☐ | Bloody stool |
| ☐ | ☐ | ☐ | Fever highest temp_____ |
| ☐ | ☐ | ☐ | Vomiting |
| ☐ | ☐ | ☐ | Nausea |
| ☐ | ☐ | ☐ | Abdominal cramps |
| ☐ | ☐ | ☐ | Hemolytic Uremic Syndrome (HUS) |

*(If developed HUS, then must be reported separately as a case of HUS also)*

### *Hospitalization

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Hospitalized for this illness |

Hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

### *Death

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Died due to this illness |

Date of death: __ / __ / ____

### Predisposing Factors

☐ ☐ ☐ Antibiotics taken for this illness
☐ ☐ ☐ Underlying illness, specify_____

## LABORATORY (Please submit copies of all labs associated with this illness to DIDE)

Specimen source: ☐Stool ☐Urine ☐Blood
☐Other _____

Collection date: __ / __ / ____

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | STEC O157:H7 culture |
| ☐ | ☐ | ☐ | STEC non O157:H7 culture |
| | | | Non O157:H7 serotype: _____ |
| ☐ | ☐ | ☐ | Shiga toxin assay (EIA), ONLY -no isolation of E.coli |
| ☐ | ☐ | ☐ | Isolate submitted to state public health lab (OLS) |

## Notes (clinical/laboratory)

## INFECTION TIMELINE

*Instructions:*
*Enter onset date in grey box. Count backward to determine probable exposure period*

| | Exposure period | | Onset date |
|---|---|---|---|
| *Days from onset* | ***-8 (Max Incubation)*** | ***-1 (Min Incubation)*** | |
| ***Calendar dates:*** | __ / __ / ____ | __ / __ / ____ | __ / __ / ____ |

## EPIDEMIOLOGIC EXPOSURES

Y N U

☐ ☐ ☐ *Eat raw or undercooked hamburger, red meat, or pork?
☐ ☐ ☐ *Eat or drink raw or unpasteurized milk?
☐ ☐ ☐ *Eat unpasteurized dairy products (soft cheese from raw milk, queso fresco, etc.)?
☐ ☐ ☐ Eat sprouts (alfalfa, clover, bean)?
☐ ☐ ☐ Eat raw fruits or vegetables
☐ ☐ ☐ Work with animals or animal products (research, vet, slaughter)?
☐ ☐ ☐ Drink untreated/unchlorinated water (i.e. surface, well)?
☐ ☐ ☐ *Visit a petting zoo, farm or pet shop? Facility Name:_____
☐ ☐ ☐ *Contact with livestock or manure?
☐ ☐ ☐ Travel to another state or country? If yes, where _____
☐ ☐ ☐ Hike, camp, fish or swim? If yes, where_____

***Is case a member of a high risk occupation?**
(Mark One)
☐ Food Handler
☐ Health Care Worker
☐ Day Care Worker/Attendee
☐ Student
☐ None of Above
Employer/School Name**:** _____

Attend any group activitites, parties or gatherings? **Yes / No** If yes, list

| Date | Activity | Location |
|---|---|---|
| | | |
| | | |

Eat at any restaurant in the last 7 days? **Yes / No** If yes, list

| Date | Name of Restaurant | Location |
|---|---|---|
| | | |
| | | |

**Complete Open-Ended Food History on next page.**

Information does not need entered into WVEDSS, however it should be kept with the paper record of the case. State health department staff may request if case is later identified as part of an outbreak.

**Food History Completed? Yes / No**

## PUBLIC HEALTH ISSUES

If any household member is symptomatic, the member is epi-linked and therefore is a probable case and should be investigated further. A stool culture and disease case report should be completed**.**

| Name | Relationship to Case | Onset Date | Lab Testing |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Y N NA

☐ ☐ ☐ Employed as food handler
☐ ☐ ☐ Non-occupational food handling (e.g. pot lucks, receptions)
☐ ☐ ☐ Attends or employed in child care
☐ ☐ ☐ Household member or close contact in sensitive occupation (food, HCW, child care)
☐ ☐ ☐ Case is part of an outbreak
Outbreak Name:_____

## PUBLIC HEALTH ACTIONS

Y N NA

☐ ☐ ☐ Disease/Transmission Education Provided
* Date:_____
☐ ☐ ☐ Exclude individuals in sensitive Occupations(food, HCW, child care)
☐ ☐ ☐ Restaurant inspection
☐ ☐ ☐ Child care inspection
☐ ☐ ☐ Culture symptomatic contacts
☐ ☐ ☐ Patient is lost to follow up
☐ ☐ ☐ Other:_____

Name: _____
DOB: _____
Condition: ____STEC____

# OPEN ENDED FOOD HISTORY
## (for Enteric Diseases)

| **DAY 1 (DATE OF ONSET)** | | |
|---|---|---|
| Date: | **Food/Beverage Consumed** | **Location Where Consumed/Purchased** |
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Snacks/Other | | |

| **DAY 2 (1 day before onset)** | | |
|---|---|---|
| Date: | **Food/Beverage Consumed** | **Location Where Consumed/Purchased** |
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Snacks/Other | | |

| **DAY 3 (2 days before onset)** | | |
|---|---|---|
| Date: | **Food/Beverage Consumed** | **Location Where Consumed/Purchased** |
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Snacks/Other | | |

| **DAY 4 (3 days before onset)** | | |
|---|---|---|
| Date: | **Food/Beverage Consumed** | **Location Where Consumed/Purchased** |
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Snacks/Other | | |

| **DAY 5 (4 days before onset)** | | |
|---|---|---|
| Date: | **Food/Beverage Consumed** | **Location Where Consumed/Purchased** |
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Snacks/Other | | |