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

Hemolytic Uremic Syndrome (HUS)

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:/_/ _________

Earliest date reported to State:/_/ _________

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

☐ ☐ ☐ Thrombotic thrombocytopenic purpura (TTP)

☐ ☐ ☐ Coagulopathy (platelets <100,000)

☐ ☐ ☐ Acute anemia with microangiopathic changes

☐ ☐ ☐ Kidney (renal) abnormality or failure

☐ ☐ ☐ Kidney dialysis as a result of illness

☐ ☐ ☐ Acute or bloody diarrhea within previous 3 weeks

Predisposing Factors

☐ ☐ ☐ Antibiotics taken for this illness

☐ ☐ ☐ Underlying illness, specify__________________

*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:/_/ _________

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

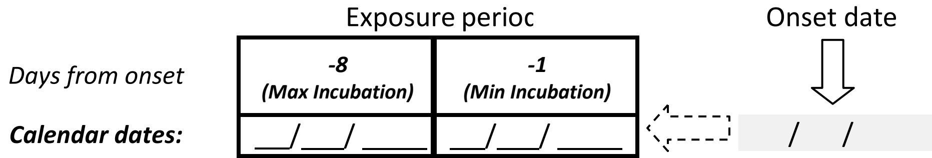
☐ ☐ ☐ Isolate submitted to state public health lab (OLS)

Notes

[£]If patient was culture positive for Shiga toxin-producing *E.coli*, they must be reported separately as a case of STEC also.

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? If yes, where ___________________________
☐ ☐ ☐ 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 outbreak
Outbreak Name: ________________________________

PUBLIC HEALTH ACTIONS

Y N NA
☐ ☐ ☐ Disease/Transmission Education Provided
☐ ☐ ☐ 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: Hemoltyic Uremic Syndrome

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		