SHIGA TOXIN-PRODUCING *ESCHERICHIA COLI* (STEC) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

General comments as of: __ __ / __ __ /__ __ __ __

General comments: _____

Name information as of: __ __ / __ __ /__ __ __ __

Last Name: _____ First Name: _____ Middle Name: _____

Suffix: _____

Sex and birth information as of: __ __ / __ __ /__ __ __ __

DOB: __ __ / __ __ /__ __ __ __ Reported Age: ____☐ Minutes ☐ Hours ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Unknown

Current Sex: ☐ Female ☐ Male ☐ Unknown

Mortality information as of: __ __ / __ __ /__ __ __ __

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Deceased date: __ __ / __ __ /__ __ __ __

Marital status as of: __ __ / __ __ /__ __ __ __ Marital status: _____

Address information as of: __ __ / __ __ /__ __ __ __

Street Address 1: _____

Street Address 2: _____

City:_____ State:_____ Zip Code:_____

County:_____ Country: _____

Telephone information as of: __ __ / __ __ /__ __ __ __

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____ Phone Number Type: ☐ Home ☐ Cell ☐ Work

Ethnicity information as of: __ __ / __ __ /__ __ __ __

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race information as of: __ __ / __ __ /__ __ __ __

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Jurisdiction: _____ Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed

Investigator: _____ Date assigned to investigation: __ __ / __ __ /__ __ __ __

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting source: _____

Earliest date reported to County: __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __**Reporter:** _____

CLINICAL

Physician: _____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes: Hospital Name: _____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Illness duration: _____ day(s)

Age at Onset: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ unknown ☐ weeks ☐ years

Is the patient pregnant?: ☐ No ☐ Unknown ☐ Yes

Does the patient have pelvic inflammatory disease?: ☐ No ☐ Unknown ☐ Yes

Did the patient die from this illness? ☐ No ☐ Unknown ☐ Yes

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐ No ☐ Unknown ☐ Yes

Is this patient a food handler? ☐ No ☐ Unknown ☐ Yes

Is this case part of an outbreak? ☐ No ☐ Unknown ☐ Yes If yes, outbreak name: _____

Where was the disease acquired? ☐ Indigenous, within jurisdiction ☐ Out of Country ☐ Out of jurisdiction, from another jurisdiction ☐ Out of State ☐ Unknown

If the answer is out of country, jurisdiction, or state, where was the disease imported from?

Country: _____State or Territory: _____City: _____County: _____

Transmission Mode: ☐ Airborne ☐ Bloodborne ☐ Dermal ☐ Foodborne ☐ Indeterminate ☐ Mechanical ☐ Nosocomial ☐ Sexually Transmitted ☐ Transplacental transmission ☐ Vectorborne ☐ Waterborne ☐ Zoonotic ☐ Unknown

Detection method: ☐ Provider reported ☐ Patient self-referral ☐ Prenatal testing ☐ Prison entry screening ☐ Routine physical ☐ Other

Confirmation method:☐ Active Surveillance ☐ Case/Outbreak Investigation ☐ Clinical diagnosis (non-laboratory confirmed) ☐ Epidemiologically linked ☐ Laboratory confirmed ☐ Laboratory report ☐ Local/State specified ☐ Medical record review ☐ No information given ☐ Occupational disease surveillance ☐ Provider certified ☐ Other _____ Confirmation date: __ __ / __ __ /__ __ __ __

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown

MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General comments:

_____

_____

_____

CUSTOM FIELDS

(For State-level Use Only) ARWFTI: _____

(For State-level Use Only) CSV: _____

Country of Usual Residence: _____

Guidelines for Determining Residency for Disease Notification Purposes

JEFFERSON COUNTY ONLY

Date Due: __ __ / __ __ /__ __ __ __

Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete) ☐ Reviewed (Not a case) ☐ Yes

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __

Review comments (completed by supervisor): _____

CONDITION SPECIFIC CUSTOM FIELDS

Signs and symptoms

Diarrhea: ☐ No ☐ Unknown ☐ Yes HUS: ☐ No ☐ Unknown ☐ Yes

Abdominal Cramps: ☐ No ☐ Unknown ☐ Yes Other (signs and symptoms): _____

Associated cases

Is this case epidemiologically linked to a confirmed case? ☐ No ☐ Unknown ☐ Yes

If yes, enter the associated NBS Investigation ID(s): _____

Control measures

Date of Presumptive Diagnosis: __ __ / __ __ /__ __ __ __

CONTROL MEASURES IMPLEMENTED (Answer all)

Date ADPH investigator verbally provided patient, or patient representative, with control measures: __ __ / __ __ /__ __ __ __

If control measures were not verbally provided (or not provided within the recommended timeframe), explain:

_____

Education case/contacts: ☐ No ☐ Unknown ☐ Yes

Exclusions: child care, food handling as applicable: ☐ No ☐ Unknown ☐ Yes

Contact tracing (identification of exposed individuals and additional cases): ☐ No ☐ Unknown ☐ Yes ☐ Not Applicable

DAY CARE

Attend a day care center? ☐ No ☐ Unknown ☐ Yes

Work at a day care center? ☐ No ☐ Unknown ☐ Yes

Live with a day care center attendee? ☐ No ☐ Unknown ☐ Yes

If yes to any of the 3 questions answer the following questions:

What type of day care facility? ☐ Adult day health care ☐ Adult day social care ☐ Alzheimer's specific day care ☐ Child care center ☐ child care provided by relative, friend, neighbor ☐ in-home caregiver

What is the name of the day care facility? _____

Is food prepared at this facility ☐ No ☐ Unknown ☐ Yes

Does this facility care for diapered persons? ☐ No ☐ Unknown ☐ Yes

TRAVEL HISTORY

Did the patient travel prior to onset of illness? ☐ No ☐ Unknown ☐ Yes Applicable incubation period for this illness is: **10 days**

Applicable incubation period for this illness is: **10 days**

What was the purpose of travel? ☐ Business ☐ Migration (immigration to US) ☐ Other _____ ☐ Tourism ☐ Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train Arrival Date: __ __ / __ __ /__ __ __ __

Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train Arrival Date: __ __ / __ __ /__ __ __ __

Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train Arrival Date: __ __ / __ __ /__ __ __ __

Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here:

_____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐ Do not use tap water ☐ Municipal, city, or county ☐ Private well ☐ Unknown

☐ Other_____

If "Private Well", how was home well water treated? ☐ Both filtered and disinfected ☐ Disinfected ☐ Filtered

☐ Neither filtered nor disinfected ☐ Unknown

What is the source of tap water at school/work? ☐ Do not use tap water ☐ Municipal, city, or county ☐ Private well ☐ Unknown

☐ Other_____

If "Private Well", how was school/work well water treated? ☐ Both filtered and disinfected ☐ Disinfected ☐ Filtered

☐ Neither filtered nor disinfected ☐ Unknown

Did the patient drink untreated water in the 7 days prior to onset of illness (e.g., from a river while camping)?

☐ No ☐ Unknown ☐ Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the 7 days prior to illness? ☐ No ☐ Unknown ☐ Yes

What was the recreational water exposure type? (select all that apply)

☐ Hot Spring ☐ Hot Tub-Whirlpool-Jacuzzi-Spa ☐ Interactive Fountain ☐ Lake-Pond-River-Stream

☐ Ocean ☐ Other _____ ☐ Recreational Water Park ☐ Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐ Camp Pool ☐ Hospital/Therapy Pool ☐ Hotel/Motel/Resort Vacation Pool

☐ Kiddie/Wading Pool ☐ Municipal/Community Pool ☐ Neighborhood/subdivision/Apartment/Condo Pool

☐ Other, specify_____ ☐ Private Club/Membership Pool ☐ Private Home Pool, not a kiddie/wading pool

☐ School/College/University Pool ☐ Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal? ☐ No ☐ Unknown ☐ Yes

If yes, select type of animal: ☐ Cat ☐ Cattle ☐ Chicken ☐ Dog ☐ Goats ☐ Lizard ☐ Poultry

☐ Rodent ☐ Sheep ☐ Swine ☐ Turtle ☐ Unknown

☐ Other, specify: _____

Name or location of animal contact: _____

Did a patient acquire a pet prior to onset of illness? ☐ No ☐ Unknown ☐ Yes

Applicable incubation period for this illness is: _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

☐ CSF leak ☐ Hodgkin's disease ☐ IVDU ☐ Alcohol abuse ☐ Asthma ☐ Atherosclerotic cardiovascular disease

☐ (ASCVD)/CAD ☐ Burns ☐ Cerebral vascular accident (CVA) stroke ☐ Chronic GI illness/diarrhea

☐Cirrhosis/liver failure ☐ Cochlear implant ☐Current smoker ☐Deaf/profound hearing loss

☐ Diabetes mellitus (insulin): ☐No ☐Unknown ☐Yes ☐ Emphysema/COPD

☐ Gastric surgery (type): _____ ☐ Heart failure ☐ Hematologic disease (type): _____

☐ Immunodeficiency (type): _____ ☐ Immunoglobulin deficiency ☐ Immunosuppressive therapy (steroids, chemotherapy)

☐ Leukemia ☐ Multiple myeloma ☐ Nephrotic Syndrome ☐ None

☐ Organ transplant (organ): _____ ☐ Other liver disease (type): _____

☐ Other malignancy (type): _____ ☐Other prior illness (type): _____

☐ Other renal disease (type): _____ ☐ Peptic ulcer ☐ Renal failure/dialysis ☐ Sickle cell anemia

☐ Splenectomy/asplenia

☐ Systemic lupus erythematosus (SLE) ☐ Unknown

RELATED CASES

Does the patient know of any similarly ill persons? ☐ No ☐ Unknown ☐ Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further:

☐ No ☐ Unknown ☐ Yes

Are the other cases related to this one? ☐ No, sporadic ☐ Unknown ☐ Yes, household ☐ Yes, not household ☐ Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the ALNBS Investigation.

FOODNET

Food Net Case? ☐

OTHER CLINICAL DATA

Did patient have HUS? ☐ No ☐ Unknown ☐ Yes

Was the isolate biochemically identified as *E. coli*? ☐ No ☐ Unknown ☐ Not Tested ☐ **Yes**

Was isolate Shiga toxin positive? ☐ No ☐ Unknown ☐ Not Tested ☐ **Yes**

What was the EIA result at clinical laboratory? ☐ Negative ☐ Not Tested ☐ Positive undifferentiated ☐ **Stx 1+** ☐ **Stx 1+ and Stx 2+** ☐ **Stx 2+**

What was the PCR result at clinical laboratory? ☐ Negative ☐ Not Tested ☐ Positive undifferentiated ☐ **Stx 1+** ☐ **Stx 1+ and Stx 2+** ☐ **Stx 2+**

What was the EIA result at SPHL? ☐ Negative ☐ Not Tested ☐ Positive undifferentiated ☐ **Stx 1+** ☐ **Stx 1+ and Stx 2+** ☐ **Stx 2+**

What was the PCR result at SPHL? ☐ Negative ☐ Not Tested ☐ Positive undifferentiated ☐ **Stx 1+** ☐ **Stx 1+ and Stx 2+** ☐ **Stx 2+**

What was the PCR result at CDC? ☐ Negative ☐ Not Tested ☐ Positive undifferentiated ☐ **Stx 1+** ☐ **Stx 1+ and Stx 2+** ☐ **Stx 2+**

Did the patient have bloody diarrhea during this illness? ☐ No ☐ Unknown ☐ Yes

Did the patient have diarrhea (self-reported)? ☐ No ☐ Unknown ☐ Yes

Did the patient have fever (self-reported) during this illness? ☐ No ☐ Unknown ☐ Yes

SHIGA TOXIN-PRODUCING *ESCHERICHIA COLI* (STEC)

INVESTIGATION SUPPLEMENTAL FORM

PHEP PROJECT

Presumptive diagnosis date: __ __ / __ __ /__ __ __ __

Initial report method: ☐ ELR ☐ E-mail ☐ Fax ☐ Mail ☐ Phone ☐ Other_____

Initial report to Public Health provided by: ☐ ELR ☐ Emergency Room ☐ Infection Preventionist/Hospital ☐ Microbiologist/Hospital ☐ Patient ☐ Physician/Practitioner ☐ Other_____

Control Measures:

Date control measures implemented: __ __ / __ __ /__ __ __ __

Education of case/contacts: ☐ No ☐ Unknown ☐ Yes Exclusion from food handling: ☐ No ☐ Unknown ☐ Yes

Exclusion from healthcare: ☐ No ☐ Unknown ☐ Yes Exclusion from daycare/school: ☐ No ☐ Unknown ☐ Yes

Identification of exposed individuals: ☐ No ☐ Unknown ☐ Yes Identification of additional cases: ☐ No ☐ Unknown ☐ Yes

Identification of possible source of infection: ☐ No ☐ Unknown ☐ Yes Collection of food: ☐ No ☐ Unknown ☐ Yes

Other measure: _____

RESTAURANTS AND GROCERY STORES

*Did you eat out at any restaurants (including fast food restaurants, delis, and take-out or home delivery meals) during the **10 days** before your illness?* ☐ No ☐ Unknown ☐ Yes

If Yes, list names and locations of restaurants.

Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____

*Where did you purchase groceries that were eaten during the **10 days** before your illness (including specialty stores, produce or fruit stands, dairy marts, etc.)?*

Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____

DETAILED FOOD HISTORY

Did you eat steak at home? ☐ No ☐ Unknown ☐ Yes

If yes, purchase location for steak eaten at home _____

Did you eat steak outside the home? ☐ No ☐ Unknown ☐ Yes

If yes, purchase location for steak eaten outside the home_____

Did you eat any of the following?

Bison: ☐ No ☐ Unknown ☐ Yes

Venison: ☐ No ☐ Unknown ☐ Yes

Elk: ☐ No ☐ Unknown ☐ Yes

Boar: ☐ No ☐ Unknown ☐ Yes

Other wild game: ☐ No ☐ Unknown ☐ Yes

If other, please specify: _____

Did you eat dried or fermented meat such as jerky, pepperoni, salami, or summer sausage?

If yes, type of dried or fermented meat eaten: _____

B. Fresh/uncooked Salads and Vegetables

Did you eat iceberg lettuce at home? (For example, whole leaf or shredded, on salad, burger, taco, or sandwich)

☐ No ☐ Unknown ☐ Yes

If yes, brand, variety of iceberg lettuce eaten at home_____

If yes, was the iceberg lettuce ☐ loose and/or ☐ prepackaged

Did you eat iceberg lettuce outside the home? (For example, whole leaf or shredded, on salad, burger, taco, or sandwich)

☐ No ☐ Unknown ☐ Yes

If yes, purchase location: _____

Did you eat romaine lettuce at home? (For example, whole leaf or shredded, on salad, wrap, or sandwich)

☐ No ☐ Unknown ☐ Yes

If yes, brand, variety of romaine lettuce eaten at home_____

If yes, was the romaine lettuce eaten at home □ loose and/or □ prepackaged

Did you eat romaine lettuce outside the home? (For example, whole leaf or shredded, on salad, wrap, or sandwich)

□ No □ Unknown □ Yes

If yes, purchase location: _____

Did you eat fresh spinach at home? (For example, whole leaf or chopped, on salad, wrap, or sandwich) □ No □ Unknown □ Yes

If yes, brand, variety of spinach eaten at home_____

If yes, was the spinach eaten at home □ loose and/or □ prepackaged

Did you eat spinach outside the home? □ No □ Unknown □ Yes

If yes, purchase location: _____

Did you eat any other leafy green vegetable such as mesclun or red leaf lettuce? □ No □ Unknown □ Yes

If yes, please specify type of other leafy green _____

Did you eat sprouts (for example, from a salad bar or on a sandwich)? □ No □ Unknown □ Yes

If yes, please specify purchase location: _____

C. Dairy or Juice

Did you drink raw milk? □ No □ Unknown □ Yes

Did you eat cheese made from raw milk (such as queso fresco or queso blanco)? □ No □ Unknown □ Yes

Did you eat artisanal or gourmet cheese? □ No □ Unknown □ Yes

Did you drink unpasteurized juice or cider? □ No □ Unknown □ Yes