HEMOLYTIC UREMIC SYNDROME (HUS) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

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

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

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

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

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

INVESTIGATION SUMMARY

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

REPORTING SOURCE

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

CLINICAL

Physician's Name:_____ 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: __ __ / __ __ /__ __ __ __

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

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

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:_____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CLINICAL INFORMATION

Physician diagnosed with HUS or TTP? ☐No ☐Unknown ☐Yes

Did patient experience acute diarrhea within the **3 weeks** preceding HUS/TTP diagnosis? ☐No ☐Unknown ☐Yes

Anemia with microangiopathic changes? ☐No ☐Unknown ☐Yes

Renal injury (acute onset) evidenced by either hematuria, proteinuria, or elevated creatinine level? ☐No ☐Unknown ☐Yes

ASSOCIATED DISEASE

Enter Investigation ID for patient's associated investigation (e.g., STEC): _____