CASE ID__ __ __ __ --__ __ -- __ __ __

Hemolytic Uremic Syndrome Surveillance
Georgia Division of Public Health

Case Report Form

Instructions: Complete the following by interviewing the attending physician and/or reviewing patient's medical record.

I. PATIENT IDENTIFICATION

1A. Patient name _____ (last) _____ (first) **2A. Date of birth** ____/____/____ (mo / day / yr)

3A. Parent/guardian _____ (last) _____ (first) **4A*. Medical Rec #** _____

5A. Address _____ (number/street) _____ (city) _____ (state) _____ (zip)

6A. Phone home (____) _____ **7A. Phone work** (____) _____ **8A. County of residence** _____

9A*. Sex ☐ Female ☐ Male

10A. Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

11A. Race ☐ White ☐ Asian / Pacific Islander ☐ Black ☐ American Indian / Alaska Native
☐ Other _____ ☐ Unknown

12A. Are you completing this form for a case identified by ICD9 code review of hospital discharge data?
- ☐ no (skip to 14A)
- ☐ yes

13A. Has this case been previously reported (either through the provider network or other source)?
- ☐ no ----> Complete questions marked by an asterisk (*) on forms A, B, and C
- ☐ yes ----> Stop here. Staple this form to patient s original report, and update database, changing answers for this and the previous question (12A and 13A only) to yes

II. HOSPITAL INFORMATION

14A. Person reporting case _____ **15A. Phone** (_____)_____

16A. Attending physician _____ **17A. Phone** (_____)_____

18A*. Hospital _____ (Name) _____ (City/State) **19A*. Phone** (_____)_____

20A*. Date of admission or transfer to this facility ____/____/____

21A*. Date of discharge or transfer from this facility ____/____/____ ☐ Still hospitalized

22A. Institution transferred to (if applicable) _____ (Name) _____ (City/State)

23A. Institution where first hospitalized (if different) _____ (Name) _____ (City/State)

24A. Date of initial hospitalization (if different) ____/____/____

25A. Physician, initial hospitalization (if different) _____ **26A. Phone** (_____)_____

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III. CLINICAL INFORMATION

27A*. Date of HUS diagnosis ____/____/____

28A*. Did patient have diarrhea during 3 weeks before HUS diagnosis?..... ☐ yes ☐ no ☐ unsure

if yes 29A.* Date of diarrhea onset _____/_____/_____

30A. Did stools contain visible blood at any time ..... ☐ yes ☐ no ☐ unsure

31A. Was diarrhea treated with antimicrobial medications..... ☐ yes ☐ no ☐ unsure

Other medical conditions present during 3 weeks before HUS diagnosis:

32A*. Urinary tract infection ..... ☐ yes ☐ no ☐ unsure

33A*. Respiratory tract infection ..... ☐ yes ☐ no ☐ unsure

34A*. Pregnancy ..... ☐ yes ☐ no ☐ unsure

35A*. Malignancy..... ☐ yes ☐ no ☐ unsure

36A*. Transplanted organ or bone marrow..... ☐ yes ☐ no ☐ unsure

37A*. HIV infection..... ☐ yes ☐ no ☐ unsure

Laboratory values within 7 days before and 3 days after HUS diagnosis:

38A*. Highest serum creatinine..... _____ mg/dL ☐ not done

39A. Highest serum BUN ..... _____ mg/dL ☐ not done

40A. Highest serum amylase..... _____ U/L ☐ not done

41A. Highest WBC ..... _____ K/mm^3 ☐ not done

42A*. Lowest hemaglobin ..... _____ g/dL ☐ not done

or Lowest hematocrit ..... _____ % ☐ not done

43A*. Lowest platelet count ..... _____ K/mm^3 ☐ not done

Other laboratory findings within 7 days before and 3 days after HUS diagnosis:

44A*. Blood smear with microangiopathic changes (i.e., schistocytes, burr cells, helmet cells or red cell fragments)..... ☐ yes ☐ no ☐ unsure ☐ not done

45A*. Blood in urine by dipstick..... ☐ yes ☐ no ☐ unsure ☐ not done

46A*. Protein in urine by dipstick..... ☐ yes ☐ no ☐ unsure ☐ not done

47A*. RBC in urine by microscopy..... ☐ yes ☐ no ☐ unsure ☐ not done

48A. Patient's blood type_____ ☐ unknown

To be completed by health department

49A. How was patient's illness <u>first</u> identified by health department?

- ☐ Report of HUS case by a participating* physician or service
- ☐ Report of HUS case by a non-participating physician or service
- ☐ Routine O157 surveillance
- ☐ Other, describe_____

*member of active HUS surveillance network

50A. Is this case outbreak related?..... ☐yes ☐no ☐ unsure_____

51A. Status of report ☐Initial ☐Update ☐Complete

52A. Date ____/____/____ 53A. Completed by (initials)_____

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Hemolytic Uremic Syndrome Surveillance
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Microbiology Report Form

Instructions: Complete by contacting microbiology laboratory at each institution where patient was treated. Complete one composite form for all laboratories.

1B. Patient name _____ **2B. Date of birth** ____/____/___
last first

3B*. Was stool specimen obtained from this patient ..... ☐ yes ☐ no ☐ unsure
if no, go to question 26B

4B. Laboratories where stool(s) tested

_____ **Phone (____) _____**
Name City/State

_____ **Phone (____) _____**
Name City/State

_____ **Phone (____) _____**
Name City/State

_____ **Phone (____) _____**
Name City/State

5B. Was stool tested for Shiga toxin ..... ☐ yes ☐ no ☐ unsure

if yes **6B. Methods(s)/kit(s) used**_____
7B. Result..... ☐ positive ☐ negative ☐ unsure
8B. Collection date 1st specimen tested: ____/____/____
9B. Collection date 1st positive specimen: ____/____/____

10B*. Was stool cultured for *E. coli* O157?..... ☐ yes ☐ no ☐ unsure

if no ***skip to question #6***
if yes **11B. Collection date 1st specimen tested for O157 ____/____/____**
12B. Methods used
☐ culture on sorbitol-MacConkey agar
☐ other, describe_____

13B. Was *E. coli* O157 isolated?..... ☐ yes ☐ no ☐ unsure
if yes **14B. Collection date 1st positive specimen: ____/____/____**
15B. Result of H antigen testing *(check one)*:
☐ H7 positive ☐ other H, specify:_____
☐ H7 negative ☐ unsure or not tested

CASE ID__ __ __ __ --__ __ -- __ __ __

16B. Was non-O157 Shiga toxin-producing *E. coli* isolated..... ☐ yes ☐ no ☐ unsure

if yes 17B. Serotype:O:____ H:____ ☐ unknown
18B. Collection date 1st specimen tested: ____/____/____
19B. Collection date 1st positive specimen: ____/____/____

20B. Other pathogen isolated from stool..... ☐ yes ☐ no ☐ unsure

if yes 21B. Pathogen #1_____ Specimen collection date ____/____/____
22B. Pathogen #2_____ Specimen collection date ____/____/____

If O157 or other STEC was isolated, complete the following based on health department records:

23B. Disposition of isolate
☐ Sent to state laboratory (reference # _____)
☐ Sent to CDC
☐ Sent to other reference laboratory (specify _____)
☐ Discarded

24B. Identity of isolate confirmed by state Public Health Laboratory
☐ yes
☐ no
☐ unsure
☐ not tested

Comment_____

25B. PHLIS reference number:_____

26B. Has patient serum been tested for antibodies to O157 or other STEC?..... ☐ yes ☐ no ☐ unsure

if yes

27B. Serogroup O157 Titers : IgG 1:____ Interpretation ☐ positive ☐ negative ☐ borderline
IgM 1:____ Interpretation ☐ positive ☐ negative ☐ borderline

28B. Serogroup O111 Titers : IgG 1:____ Interpretation ☐ positive ☐ negative ☐ borderline
IgM 1:____ Interpretation ☐ positive ☐ negative ☐ borderline

29B. Serogroup O26 Titers : IgG 1:____ Interpretation ☐ positive ☐ negative ☐ borderline
IgM 1:____ Interpretation ☐ positive ☐ negative ☐ borderline

30B. Status of report ☐ initial ☐ update ☐ complete

31B. Date ____/____/____ 32B. Completed by (initials) _____

Hemolytic Uremic Syndrome Surveillance
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Revised 11/20/00

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Chart Review Form

Instructions: Complete after patient has been discharged; use hospital discharge summary, consultation notes and DRG coding sheet. Complete one composite form for all institution where hospitalized.

1C. Patient name _____ _____ **2C. Date of birth** ____/____/____
last first

3C. Hospitals admitted _____ **Phone** (____) _____
Date admitted above:____/____/___ **Date discharged above:**____/____/___

_____ **Phone** (____) _____
Date admitted above:____/____/___ **Date discharged above:**____/____/___

_____ **Phone** (____) _____
Date admitted above:____/____/___ **Date discharged above:**____/____/___

_____ **Phone** (____) _____
Date admitted above:____/____/___ **Date discharged above:**____/____/___

4C. Date of first admission:____/____/___ **5C. Date of last discharge:**____/____/___

Did any of the following complications occur during this admission:

						Date of onset
8C*	Pneumonia.....	☐ yes	☐ no	☐ unsure	9C. *if yes*	___/___/___
10C*	Seizure.....	☐ yes	☐ no	☐ unsure	11C. *if yes*	___/___/___
12C*	Paralysis or hemiparesis.....	☐ yes	☐ no	☐ unsure	13C. *if yes*	___/___/___
14C*	Blindness.....	☐ yes	☐ no	☐ unsure	15C. *if yes*	___/___/___
16C*	Positive blood culture.....	☐ yes	☐ no	☐ unsure	17C. *if yes*	___/___/___
	if yes, Pathogen(s) isolated: _____					
18C*	Other major neurologic sequelae	☐ yes	☐ no	☐ unsure	19C. *if yes*	___/___/___
	if yes, Describe: _____					

Were any of the following procedures performed during this admission:

20C*	Peritoneal dialysis.....	☐ yes	☐ no	☐ unsure
21C*	Hemodialysis.....	☐ yes	☐ no	☐ unsure
	Transfusion with:			
22C.	packed RBC or whole blood.....	☐ yes	☐ no	☐ unsure
23C.	platelets.....	☐ yes	☐ no	☐ unsure
24C.	fresh frozen plasma.....	☐ yes	☐ no	☐ unsure
25C*	Plasmapheresis	☐ yes	☐ no	☐ unsure
26C	Laparotomy or other abdominal surgery*.....	☐ yes	☐ no	☐ unsure
	*other than insertion of dialysis catheter			
27C	*if yes to surgery*, Describe:_____			

28C*. Condition at discharge..... ☐ dead ☐ alive

29C	*if dead*, Date deceased:____/____/____			
30C*	*if alive*, Requiring dialysis.....	☐ yes	☐ no	☐ unsure
31C*	With neurologic deficits.....	☐ yes	☐ no	☐ unsure

32C. Status of report ☐ initial ☐ update ☐ complete

33C. Date ___/___/___ **34C. Completed by (intials)**_____

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