

Shiga-toxigenic *E. coli*

(*Escherichia coli* O157, others)

ALASKA

FOR STATE USE ONLY

____ / ____ / ____ case report

____ / ____ / ____ interstate

- confirmed
- presumptive
- suspect
- no case

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) home (H), work (W), cell (C), message (M)

Address _____
Street City Zip

email _____ Language _____

ALTERNATIVE CONTACT Parent Spouse Friend _____

Name _____ Phone(s) _____
LAST, first, initials home (H), work (W), cell (C), message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

ELR Lab (not ELR) ICP

Physician _____

Reporter _____

Date of first report ____ / ____ / ____

Primary MD _____

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX female male

DOB ____ / ____ / ____
m d y

if DOB unknown, AGE _____

HISPANIC Y N ?

RACE (check all that apply)

white AI/AN

black Pacific Islander

Asian refused to answer

unknown _____

Worksites/school/day care center _____

Occupation/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic Y N ?

first symptoms ____ / ____ / ____
m d y

first vomit/diarrhea ____ / ____ / ____

first V/D time _____ am pm

diarrhea Y N ?

bloody diarrhea Y N ?

HUS Y N ?

TTP Y N ?

ER visit Y N ?

Hospital Admission Y N ?

Hospital 1 _____

date of admission ____ / ____ / ____

date of discharge ____ / ____ / ____

Transferred Y N ?

Hospital 2 _____

date of admission ____ / ____ / ____

date of discharge ____ / ____ / ____

Outcome survived died ?

date of death ____ / ____ / ____
m d y

PRIVATE LAB DATA

Specimen collected ____ / ____ / ____
m d y

stool urine _____

Lab _____

Shiga-toxin pos neg not done

if yes stx1 stx2 unspecified

O157 confirmed Y N
 (or presumptive)

PUBLIC HEALTH LAB DATA

submitted to PHL Y N ?

PHL specimenID _____
e.g., G11-1875

STEC isolated Y N

O antigen O157

O26 O45 O103 O111

O121 O145 _____

Flagella H7 NM _____

Shiga toxin stx1 stx2

EPILINKS

At the time of initial report, case appears to be:

sporadic

part of a household cluster

part of a multi-household outbreak OutbreakID _____

Case appears to be primary secondary

If a contact of a confirmed or presumptive case, nature of contact:

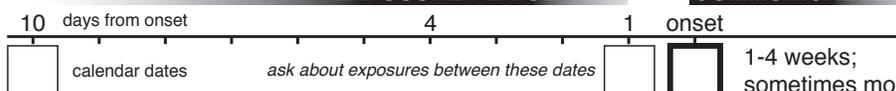
household sexual child care _____

Specify linked cases; other details as needed.

INFECTION TIMELINE

Enter onset date in heavy box.
 Count back to figure the probable
 exposure period.

EXPOSURE PERIOD



COMMUNICABLE

1-4 weeks;
 sometimes more



POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

case (or family proxy) could not be interviewed no risk factors identified exempt (part of already recognized outbreak, shotgun interview, etc.)

Interviewees case parent physician other HCP _____ Interview date(s) _____

Provide ancillary details (names, locations, dates) about possible sources and risk factors checked below.

Y N HIGH-RISK FOODS**

- ground beef** handling by anyone at home
- ground beef**consumption by case
- rare/raw meat**
- raw milk**
- queso fresco/raw milk cheese**
- venison or other game**
- dried meat (salami, jerky, etc.)**
- sprouts (alfalfa, clover, bean, ...)**
- unpasteurized juice/cider**

Y N OTHER POTENTIAL SOURCES

- food at restaurants
- food at other gatherings (potlucks, events)
- work exposure to human or animal excreta
- diaper changing
- exposure to kids in child care settings
- recreational water exposure (pools, lakes, rivers, water parks, backyard splash pools, ...)
- livestock or farm exposure
- animal exhibits (petting zoos, fairs, 4H, etc.)

Y N TRAVEL

- outside U.S. to _____
- outside Alaska to _____
- within Alaska to _____

Provide details about all travel; see Orpheus.

departure ___/___/___

return ___/___/___
 m d y

****Ask about any leftovers, including packaging or containers in the trash; collect same for testing. Contact SOE for details.**

There are no leftovers or packaging that can be tested

TREATMENT Was patient treated with antibiotics or antimotility drugs for this illness? Y N ? *if yes, specify type, dose, and dates given.*

CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER

name	age	sex	occupation	diarrhea			onset	education provided			comment
				Y	N	?		Y	N	?	
_____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___ m d y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does the case know about anyone else with a similar illness? Y N *If yes, get contact information, onsets, etc.*

If the case is a food handler, HCW with direct patient contact, or works at or attends daycare, provide details about worksite, job description, dates worked or attended during communicable period (as applicable), supervisor, etc. If the patient attends daycare or nursery school, institute active surveillance.

Contact person/phone number _____

Is the patient in diapers? Y N

Are other children or staff ill? Y N

SUMMARY OF FOLLOW-UP AND COMMENTS *Provide details as appropriate.*

- hygiene education provided child care restriction work or school restriction for case child care inspection food testing
- restaurant evaluation _____

ADMINISTRATION Fax to 907-563-7868

Copy patient's name to the top of this page.

Fax to Alaska Section of Epidemiology at (907) 563-7868

Completed by _____ Phone _____ Completed case report ___/___/___