

# Shiga-toxigenic *E. coli*

(*Escherichia coli* 0157 and others)

Orpheus ID

- confirmed
- presumptive
- suspect
- no case

Name \_\_\_\_\_ County \_\_\_\_\_  
LAST, first, initials (a.k.a.)

Special housing \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip

Phone number \_\_\_\_\_ / \_\_\_\_\_  
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

**ALTERNATIVE CONTACT**

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

**DEMOGRAPHICS PROVIDERS, FACILITIES AND LABS**

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
m d y  
 if DOB unknown, AGE \_\_\_\_  
 Sex  female  male  
 Language \_\_\_\_\_  
 Country of birth \_\_\_\_\_  
 Worksites/school/day care center \_\_\_\_\_  
 Occupation/grade \_\_\_\_\_

RACE (check all that apply)  
 White  
 Black  
 Asian  
 Pacific Islander  
 American Indian/Alaska Native  
 unknown  
 other \_\_\_\_\_  
 HISPANIC  
 Yes  No  
 unknown  declined

Reporter \_\_\_\_\_ Type (circle one)  
 \_\_\_\_\_ name and phone number  
 PMD Lab-fax  
 MDx Lab-phone  
 ER Lab-other  
 CP HCP  
 Lab-ELR  
 Reporter \_\_\_\_\_ Type (circle one)  
 \_\_\_\_\_ name and phone number  
 PMD Lab-fax  
 MDx Lab-phone  
 ER Lab-other  
 CP HCP  
 Lab-ELP  
 Ok to contact patient  
 Local epi name \_\_\_\_\_  
 Date report received by LHD \_\_\_\_/\_\_\_\_/\_\_\_\_  
 LHD completion date \_\_\_\_/\_\_\_\_/\_\_\_\_

**BASIS OF DIAGNOSIS**

CLINICAL DATA  
 Symptomatic  yes  no  unk  
 first symptoms \_\_\_\_/\_\_\_\_/\_\_\_\_  
 first vomit/diarrhea \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Time: \_\_\_\_\_ am/pm  
 diarrhea  yes  no  unk  
 bloody diarrhea  yes  no  unk  
 vomiting  yes  no  unk  
 HUS  yes  no  unk  
 TTP  yes  no  unk

Deceased  yes  no date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Cause: \_\_\_\_\_  
 Hospitalized:  yes:  no  unk  ICU  
 Name \_\_\_\_\_  
 Chart number \_\_\_\_\_  
 admit \_\_\_\_/\_\_\_\_/\_\_\_\_ discharge \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Status: Check one:  
 alive  dead  unk  transfer  
 Hospitalized:  yes:  no  unk  ICU  
 Name \_\_\_\_\_  
 Chart number \_\_\_\_\_  
 admit \_\_\_\_/\_\_\_\_/\_\_\_\_ discharge \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Status: Check one:  
 alive  dead  unk  transfer

LABORATORY DATA  
 Testing Lab \_\_\_\_\_  
 Originating Lab \_\_\_\_\_  
 Collection date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Specimen tyoe:  
 stool  other \_\_\_\_\_  
 Test Type pos neg unk  
 Culture     
 O157 Antigen     
 Shigatoxin EIA     
 if yes, STX-1  STX-2   
 Shigatoxin PCR    
 if yes, STX-1  STX-2   
 Sent to OSPHL  yes  no  unk

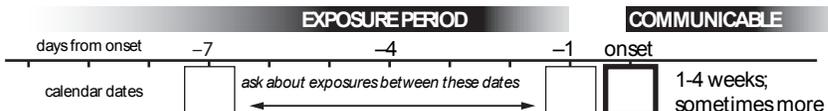
Treatment  
 Was patient treated with antibiotics or anti-motility drugs for this illness?  yes (specify)  no  unk  
 Drug name \_\_\_\_\_ size/dose/frequency \_\_\_\_\_ start date \_\_\_\_/\_\_\_\_/\_\_\_\_ end date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Comments:



**INFECTION TIMELINE**

Enter onset date in heavy box. Count back to figure the probable exposure period. Ask about risk questions in this time period.



Interviewed  yes  no Interview date(s) \_\_\_\_\_ Interviewed by \_\_\_\_\_

Who  patient  provider  parent  other

Reason not interviewed (choose one)

- not indicated  unable to reach  out of jurisdiction  deceased  
 refused  physician interview  medical record review

**POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD**

*Risks* Provide ancillary details (names, locations, details) about possible sources and risk factors. Ask about any leftovers including packaging or containers in the trash, collect some for testing. Contact ACDP for details.

- yes no ref unk **HIGH RISK FOODS**
- ground beef handling or cooked in home
  - any ground beef
  - raw/rare meat
  - raw milk
  - queso fresco/raw milke cheese
  - venison or other game
  - dried meat (salami, jerky, etc.)
  - fresh spinach, lettuce or leafy greens
  - sprouts (alfalfa, clover, bean)
  - unpasteurized juice or cider

- Y N **TRAVEL**
- outside the US to \_\_\_\_\_
  - outside Oregon to \_\_\_\_\_
  - within Oregon to \_\_\_\_\_
- Provide details about all travel, see Orpheus  
 departure \_\_\_/\_\_\_/\_\_\_ return \_\_\_/\_\_\_/\_\_\_

- yes no ref unk **OTHER POTENTIAL SOURCES**
- food at restaurants, fast food, vendors
  - food at other gatherings (potlucks and events)
  - work exposure to human or animal excreta
  - contact with diapered children or adults
  - recreational water exposure (pools, lakes, rivers, water parks, backyard splash pools....)
  - live stock or farm exposure
  - petting zoos, county fairs, 4H

Associated with a known outbreak?  yes  no  unk

Close contact of another case  yes  no  unk

Specify nature of contact

- co-worker  daycare  friend
- household  sexual

Has the above case been reported?  yes  no  unk

If yes to any question, specify names, dates, places.

Outbreak ID \_\_\_\_\_

*OTHER FOLLOW-UP.* Provide details as appropriate.

- yes no ref unk
- does the case know anyone with a similar illnesses
  - is the case in diapers
  - does case work or attend daycare
  - are other children/staff ill
  - daycare/work restriction for case

- yes no ref unk
- day care inspection as part of investigation
  - prepared food for public/private gatherings
  - restaurant inspection
  - dairy inspection
  - water supply testing
  - case educated about disease tranmission

**CONTACT MANAGEMENT FOLLOW-UP**

Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Last exposure	Onset date	Interview date	Sick
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	_____	___/___/___	___/___/___	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	_____	___/___/___	___/___/___	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	_____	___/___/___	___/___/___	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N

**ADMINISTRATION**

Remember to copy patient's name to the top of this page.

Completed by \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Case report sent to OHA on \_\_\_/\_\_\_/\_\_\_

Investigation sent to OHA on \_\_\_/\_\_\_/\_\_\_