

Hemolytic Uremic Syndrome Report Form
Ohio Department of Health

Date: _____
By: _____
Agency: _____

ODH ID # _____ - _____

Patient name: _____ DOB: ____ / ____ / ____
Last Name First Name

Parent/guardian: _____
Last Name First Name

Address: _____ City/State/Zip: _____

Home phone: (____) _____

Work phone: (____) _____ County: _____

Race: _____ White Ethnicity: _____ Hispanic
_____ Black _____ Non-Hispanic
_____ Asian _____ Unknown
_____ Native American
_____ Other: _____
_____ Unknown

Sex: _____ M _____ F _____ Unknown

Person reporting case: _____ Phone: (____) _____

Attending physician: _____ Phone: (____) _____

Currently hospitalized at: _____

City/State: _____

Date of admission or transfer to this hospital: ____ / ____ / ____

Institution where first hospitalized (if different): _____

Date of initial hospitalization (if different): ____ / ____ / ____

Date of HUS diagnosis: ____ / ____ / ____

Primary care physician (in hometown): _____ Clinic: _____

Phone: (____) _____

Epidemiologic Data

1) How many people live in the household (other than patient):

Number

_____ children < 5 years old
_____ children 5 to 17 years old
_____ adults ≥ 18 years old

2) Symptoms of case-patient during two weeks before diagnosis of HUS:

				<u>Onset Date</u>	<u>Duration (days)</u>
Felt feverish	YES	NO	UNK	_____	_____
Measured fever (max: _____ °F)	YES	NO	UNK	_____	_____
Diarrhea (≥ 3 loose stools/24 hr)	YES	NO	UNK	_____	_____
Bloody diarrhea	YES	NO	UNK	_____	_____
Vomiting	YES	NO	UNK	_____	_____
Abdominal cramps	YES	NO	UNK	_____	_____

IF DIARRHEA = YES:

Maximum # loose stools per 24 hours: _____
Red streaks in stool YES NO UNK
Gross blood in stool YES NO UNK
Mucous in stool YES NO UNK

3) Did patient consume raw milk or raw milk products during the week before onset?

Y N U

IF YES, describe: _____

4) Did patient visit a dairy farm during the week before onset?

Y N U

IF YES, describe: _____

5) Did patient eat hamburger prepared at a restaurant during the week before onset?

Y N U

a) Restaurant: _____ Address: _____

Date visited: _____ Menu items: _____

Did meat appear undercooked (i.e., pink in center)? Y N U

Did anyone else eat same hamburger item? Y N U

IF YES, describe: _____

b) Restaurant: _____ Address: _____

Date visited: _____ Menu items: _____

Did meat appear undercooked (i.e., pink in center)? Y N U

Did anyone else eat same hamburger item? Y N U

IF YES, describe: _____

6) Did patient eat hamburger prepared at home during the week before onset?

Y N U

IF YES, date(s) eaten: _____

Describe meal(s): _____

Did meat appear undercooked (i.e., pink in center)? Y N U

Did anyone else eat same hamburger item? Y N U

IF YES, names of others who ate hamburger: _____

7) Did patient eat any other raw or undercooked meat (chicken, pork, etc) during the week of onset?

Y N U

Describe: _____

8) Has patient attended a day care facility anytime since 10 days prior to onset of diarrhea or cramps?

Y N U

Name of facility: _____ Phone: (____) _____

Address: _____

Director: _____

Dates of attendance: _____

(start 10 days prior to date of onset, to present)

9) Have any other household members or close contacts of the case had diarrhea since 10 days prior to the case patient's onset date?

Y N U

<u>First name</u>	<u>Relationship</u>	<u>Age</u>	<u>Diarrhea</u>	<u>Bloody diarrhea</u>	<u>Cramps</u>	<u>Onset Date</u>
_____	_____	____	Y N U	Y N U	Y N U	_____
_____	_____	____	Y N U	Y N U	Y N U	_____
_____	_____	____	Y N U	Y N U	Y N U	_____

Clinical Data

E. coli O157:H7 Stool Culture Results

	<u>Culture #1</u>	<u>Culture #2</u>	<u>Culture #3</u>	<u>Culture #4</u>
Date:	_____	_____	_____	_____
Result:	_____	_____	_____	_____

Surveillance Criteria for HUS:

Hematocrit < 30 ml/100ml	Y	N
Schistocytes, burr cells, helmet cells on smear	Y	N
Hematuria (RBCs in urine)	Y	N
Proteinuria (protein in urine)	Y	N
Creatinine level: _____ mg/dL		
Lab's normal range: _____ to _____ mg/dL		
Platelet count < 150,000/mm ³	Y	N
Did patient receive peritoneal dialysis?	Y	N
Did patient receive hemodialysis?	Y	N
Did patient receive RBC transfusion?	Y	N
Did patient receive platelet transfusion?	Y	N
Did patient have any pre-existing medical condition?	Y	N

IF YES, describe: _____

Comments or other pertinent information: _____

Please send a copy of the completed form to:
Bureau of Infectious Disease Control
Ohio Department of Health
P.O. Box 118
Columbus, OH 43266-0118