

**Appendix XIII: Case Report Form****Hemolytic Uremic Syndrome Surveillance
State Department of Health***Instructions: Complete the following by interviewing the attending physician and/or reviewing patient's medical record.***I. PATIENT IDENTIFICATION**1A. Patient name _____ 2A. Date of birth _____
last first mo / day / yr3A. Parent/guardian _____ 4A. Medical Rec # _____
last first5A. Address _____
number/street city state zip

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

9A. Sex Female Male10A. Ethnicity Hispanic Non-Hispanic Unknown11A. 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?

-
- Yes
-
-
- No Skip to Question 14A

13A. Has this case been previously reported (either through the provider network or other source)?

-
- 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"
-
-
- No ----> Complete as much information as possible on Forms A, B, and C

II. HOSPITAL INFORMATION

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

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

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

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

21A. Date of discharge or transfer from this facility ____/____/____ Still hospitalized22A. Institution transferred to (if applicable) _____
Name City/State23A. 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 the 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 unsure31A. Was diarrhea treated with antimicrobial medications..... yes no unsure*if yes* 32A. Type of antimicrobial _____33A. Was patient treated with an antimicrobial medication for any other reason than diarrhea during the 3 weeks before HUS diagnosis? yes no unsure*if yes* 34A. Type of antimicrobial _____

35A. Reason(s) _____

Other medical conditions present during 3 weeks before HUS diagnosis:

36A. Other gastrointestinal illness..... yes no unsure37A. Urinary tract infection yes no unsure38A. Respiratory tract infection yes no unsure39A. Other acute illness..... yes no unsure*if yes* 40A. Describe _____41A. Pregnancy yes no unsure42A. Kidney Disease yes no unsure43A. Immune compromising condition or medication yes no unsure*if yes* 44A. Malignancy..... yes no unsure45A. Transplanted organ or bone marrow..... yes no unsure46A. HIV infection..... yes no unsure47A. Steroid Use (parenteral or oral)..... yes no unsure

48A. Other, describe _____

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

49A. Highest serum creatinine..... _____ mg/dL

50A. Highest serum BUN _____ mg/dL

51A. Highest serum amylase..... _____ U/L

52A. Highest WBC _____ K/mm³

53A. Lowest hemoglobin _____ g/dL

or Lowest hematocrit _____ %

54A. Lowest platelet count _____ K/mm³

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

55A. Blood smear with microangiopathic changes (i.e., schistocytes, burr cells, helmet cells or red cell fragments)..... yes no unsure not tested56A. Blood in urine by dipstick..... yes no unsure not tested57A. Protein in urine by dipstick..... yes no unsure not tested58A. RBC in urine by microscopy..... yes no unsure not tested

59A. Patient's blood type _____

To be completed by health department60A. How was patient's illness first identified by health department? Report of HUS case by a participating member of the HUS active surveillance network Report of HUS case by a non-participating physician or service Routine O157 surveillance Other, describe _____61A. Is this case outbreak related?..... yes no unsure62A. Status of report Initial Update Complete

63A. Date ____/____/____ 64A. Completed by (initials) _____



Appendix XIV: Microbiology Report Form
Hemolytic Uremic Syndrome Surveillance
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Instructions: Complete by contacting microbiology laboratory at each institution where patient was treated. Complete one composite form for all laboratories.

1B. Was stool specimen obtained from this patient yes no unsure
if no Skip to question 22B

2B. Laboratories where stool(s) tested

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

3B. Was stool tested for Shiga toxin yes no unsure
if yes 4B. Methods(s)/kit(s) used _____

5B. Result..... positive negative unsure
 6B. Collection date 1st specimen tested: ____/____/____
 7B. Collection date 1st positive specimen: ____/____/____

8B. Was stool cultured for *E. coli* O157?..... yes no unsure

if no skip to question 14B

if yes 9B. Collection date 1st specimen tested for O157 ____/____/____

10B. Methods used
 culture on sorbitol-MacConkey agar
 other, describe _____

11B. Was *E. coli* O157 isolated?..... yes no unsure

if yes 12B. Collection date 1st positive specimen: ____/____/____

13B. Result of H antigen testing (*check one*):
 H7 positive other H, specify:____
 H7 negative
 unsure or not tested
 non-motile

14B. Was stool tested for non O157 Shiga toxin-producing *E. coli*? yes no unsure

if yes 15B. Was non-O157 Shiga toxin-producing *E. coli* isolated..... yes no unsure

if yes 16B. Serotype: O:____ H:____ non-motile unknown
 17B. Collection date 1st specimen tested: ____/____/____
 18B. Collection date 1st positive specimen: ____/____/____



CASE ID _____



Appendix XIV: Microbiology Report Form

19B. Other pathogen isolated from stool..... yes no unsure

if yes 20B. Pathogen #1 _____ Specimen collection date ___/___/___
21B. Pathogen #2 _____ Specimen collection date ___/___/___

22B. Pathogen isolated from source other than stool..... yes no unsure

if yes 23B. Pathogen _____
24B. Specimen Source _____
25B. First date of isolation ___/___/___

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

26B. Disposition of isolate Sent to state laboratory (reference # _____)
(check all that apply) Sent to CDC
 Sent to other reference laboratory (specify _____)
 Discarded

27B. Identity of isolate confirmed by state Public Health Laboratory

- yes
- no
- unsure
- not tested

Comment _____

28B. Is the patient a resident of the FoodNet catchment area? yes no

if yes 29B. Please complete the following based on your site's method of data transmission

PHLIS _____ - _____ - _____
Site ID Patient ID Specimen ID

NEDSS _____
NEDSS Patient ID

Method other than PHLIS or NEDSS _____
Local ID

30B. Was serum obtained from this patient? yes no unsure

if no Skip to 37B

if yes 31B. Were significant levels of antibodies against an STEC detected?..... yes no unsure

if yes 32B. LPS type _____

33B. Titer IgG _____

35B. Titer IgM _____

34B. Interpretation positive negative borderline

36B. Interpretation positive negative borderline

37B. Status of report initial update complete

38B. Date ___/___/___

39B. Completed by (initials) _____



Appendix XV: Chart Review Form

**Hemolytic Uremic Syndrome Surveillance
State Department of Health**

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. 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: ___/___/___

2C. Date of first admission: ___/___/___ 3C. Date of last discharge: ___/___/___

Did any of the following complications occur during this admission:

					Date of onset
4C. Pneumonia.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	5C. ___/___/___
6C. Seizure.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	7C. ___/___/___
8C. Paralysis or hemiparesis.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	9C. ___/___/___
10C. Blindness.....	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	11C. ___/___/___
12C. Other major neurologic sequelae	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> unsure	<i>if yes</i>	13C. ___/___/___

if yes, Describe: _____

Were any of the following procedures performed during this admission:

14C. Peritoneal dialysis..... yes no unsure

15C. Hemodialysis..... yes no unsure

Transfusion with:

16C. packed RBC or whole blood..... yes no unsure

17C. platelets..... yes no unsure

18C. fresh frozen plasma..... yes no unsure

19C. Plasmapheresis yes no unsure

20C. Laparotomy or other abdominal surgery*..... yes no unsure
 (*other than insertion of dialysis catheter)

if yes 21C. Describe: _____

22C. Condition at discharge..... dead alive

if dead, 23C. Date deceased: ___/___/___

if alive, 24C. Requiring dialysis..... yes no unsure

25C. With neurologic deficits..... yes no unsure

26C. Status of report initial update complete

27C. Date ___/___/___ 28C. Completed by (initials) _____