

California Department of Public Health  
 Center for Infectious Diseases  
 Division of Communicable Disease Control  
 Infectious Diseases Branch  
 Surveillance and Statistics Section  
 MS 7306, P.O. Box 997377  
 Sacramento, CA 95899-7377

Local ID Number \_\_\_\_\_

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary  Final

## SHIGA TOXIN-PRODUCING *ESCHERICHIA COLI* (STEC) AND/OR HEMOLYTIC UREMIC SYNDROME (HUS) CASE REPORT

Check one:       STEC without HUS       STEC with HUS       HUS without evidence of STEC

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence		Apartment / Unit Number		Ethnicity (check one)	
City / Town		State	Zip Code	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk	
Census Tract	County of Residence	Country of Residence		Race* (check all that apply, race descriptions on page 13)	
Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)		<input type="checkbox"/> African-American / Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply)		
Home Telephone	Cellular Phone / Pager	Work / School Telephone		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Thai <input type="checkbox"/> Hmong <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____	
E-mail Address		Other Electronic Contact Information			
Work / School Location		Work / School Contact			
Gender					
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)		<input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk	
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 13)		Other Describe/Specify			
Occupation (see list on page 13)		Other Describe/Specify			
*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.					

First three letters of patient's last name:

<b>CLINICAL INFORMATION</b>					
<i>Physician Name - Last Name</i>		<i>First Name</i>		<i>Telephone Number</i>	
<b>GROUP SETTING</b>					
<i>Attends child care or preschool?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			<i>Location / Other Details of Child Care, Preschool, or Skilled Nursing Facility</i>		
<i>Lives in skilled nursing facility?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
<b>SIGNS AND SYMPTOMS</b>					
<i>Symptomatic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<i>Onset Date (mm/dd/yyyy)</i>	<i>Onset Time (hh:mm)</i>	<i>Specify AM/PM</i> <input type="checkbox"/> AM <input type="checkbox"/> PM	<i>Duration of Acute Symptoms (days)</i>
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted	
Diarrhea				<i>Max. number of stools in 24-hr period</i>	<i>Onset date of diarrhea (mm/dd/yyyy)</i>
Bloody diarrhea					
Fever				<i>Highest temperature (specify °F/°C)</i>	
Vomiting					
Abdominal cramps					
<i>Other signs / symptoms (specify)</i>					
<b>HEMOLYTIC UREMIC SYNDROME (HUS)</b>					
<i>In order for a patient to be counted as a confirmed case of post-diarrheal HUS, the patient must have had an acute illness diagnosed as HUS or thrombotic thrombocytopenic purpura (TTP) that began within 3 weeks after onset of an episode of acute or bloody diarrhea. Attach discharge summary if available.</i>					
<i>Did patient have HUS? (See case definition on page 12)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			<i>If patient had HUS, did the patient have the following conditions:</i>		
			<ul style="list-style-type: none"> <li>• Anemia with microangiopathic changes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• Renal injury (hematuria, proteinuria, or elevated creatinine): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• Thrombocytopenia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul>		
<i>Did patient have thrombotic thrombocytopenic purpura (TTP)? TTP is a syndrome consisting of microangiopathic anemia, thrombocytopenic purpura, neurologic changes, fever, and renal disease.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
<i>Onset Date of HUS or TTP (mm/dd/yyyy)</i>			<i>Did patient have HUS or TTP that began within 3 weeks after onset of diarrhea?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
<i>Did the patient require dialysis?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			<i>Did patient receive antimicrobials after onset of diarrhea but before onset of HUS or TTP?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
<b>PAST MEDICAL HISTORY</b>					
<i>Did the patient take any antibiotics in the 30 days prior to illness onset?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			<i>If Yes, specify antibiotic(s)</i>		
<i>Did the patient have other underlying conditions relevant to present illness?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			<i>If Yes, specify type of condition</i>		
<i>Other (specify)</i>					
<b>HOSPITALIZATION</b>					
<i>Did patient visit emergency room for illness?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<i>Was patient hospitalized?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<i>If Yes, how many total hospital nights?</i>	
<i>If there were any ER or hospital stays related to this illness, specify details in HOSPITALIZATION – DETAILS section on page 3.</i>					

First three letters of patient's last name: 

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**HOSPITALIZATION – DETAILS**

<i>Hospital Name 1</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>
<i>Hospital Name 2</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>

**TREATMENT / MANAGEMENT**

<i>Received treatment (e.g., antibiotics, probiotics, intravenous fluids)?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, specify the treatments below.</i>
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**TREATMENT / MANAGEMENT DETAILS**

<i>Treatment Type 1</i> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	<i>Treatment Name</i>	<i>Date Started (mm/dd/yyyy)</i>	<i>Date Ended (mm/dd/yyyy)</i>
<i>Treatment Type 2</i> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	<i>Treatment Name</i>	<i>Date Started (mm/dd/yyyy)</i>	<i>Date Ended (mm/dd/yyyy)</i>

**OUTCOME**

<i>Outcome?</i> <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	<i>If Survived, Survived as of _____(mm/dd/yyyy)</i>	<i>Date of Death (mm/dd/yyyy)</i>
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**LABORATORY INFORMATION**

For details on the laboratory criteria for diagnosis and clarification of case classification, please refer to the case definition on page 11.  
 Note: Per Title 17, Shiga toxin positive broths as well as STEC O157 and non-O157 isolates must be forwarded to a public health laboratory (PHL) or CDPH Microbial Diseases Laboratory (MDL) for confirmation.

**CLINICAL LABORATORY RESULTS – Culture and Culture Independent Diagnostic Testing [CIDT], including Shiga Toxin**

<i>Specimen Type</i> <input type="checkbox"/> Stool <input type="checkbox"/> Other (specify): _____	<i>Type of Shiga Toxin Test</i> <input type="checkbox"/> Enzyme immunoassay (EIA) <input type="checkbox"/> PCR <input type="checkbox"/> Vero cell assay <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
<i>Shiga Toxin Test Result</i> <input type="checkbox"/> Stx positive <input type="checkbox"/> Stx negative <input type="checkbox"/> Unk	<i>If Stx positive, specify type of toxin(s)</i> <input type="checkbox"/> Stx 1 <input type="checkbox"/> Stx 2 <input type="checkbox"/> Stx 1 and Stx 2 <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
<i>Other CIDT identification for STEC?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If CIDT positive, specify result(s)</i> <input type="checkbox"/> <i>E. coli</i> O157 <input type="checkbox"/> Enterohemorrhagic <i>E. coli</i> <input type="checkbox"/> STEC <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
	<i>Type of Other CIDT</i> <input type="checkbox"/> PCR <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
<i>Clinical laboratory STEC culture completed?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If culture completed, specify result(s)</i> <input type="checkbox"/> <i>E. coli</i> O157 <input type="checkbox"/> STEC non-O157 <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> <i>E. coli</i> O157:H7 <input type="checkbox"/> Negative for STEC		
<i>Collection Date (mm/dd/yyyy)</i>	<i>Laboratory Name</i>	<i>Laboratory CLIA Number</i>	<i>Telephone Number</i>

(continued on page 4)

First three letters of patient's last name: 

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**CLINICAL LABORATORY RESULTS – Culture and Culture Independent Diagnostic Testing [CIDT], including Shiga Toxin (continued)**

<b>ANTIMICROBIAL SUSCEPTIBILITY TESTING</b>													
Antimicrobial susceptibility testing completed?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk  Attach additional results or upload to CalREDIE electronic filing cabinet.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Ampicillin:</td> <td> <input type="checkbox"/> Susceptible   <input type="checkbox"/> Intermediate   <input type="checkbox"/> Resistant   <input type="checkbox"/> Not done                     </td> </tr> <tr> <td>Azithromycin:</td> <td> <input type="checkbox"/> Susceptible   <input type="checkbox"/> Intermediate   <input type="checkbox"/> Resistant   <input type="checkbox"/> Not done                     </td> </tr> <tr> <td>Ciprofloxacin:</td> <td> <input type="checkbox"/> Susceptible   <input type="checkbox"/> Intermediate   <input type="checkbox"/> Resistant   <input type="checkbox"/> Not done                     </td> </tr> <tr> <td>TMP-SMX:</td> <td> <input type="checkbox"/> Susceptible   <input type="checkbox"/> Intermediate   <input type="checkbox"/> Resistant   <input type="checkbox"/> Not done                     </td> </tr> <tr> <td>Third-generation cephalosporin (specify): _____</td> <td> <input type="checkbox"/> Susceptible   <input type="checkbox"/> Intermediate   <input type="checkbox"/> Resistant   <input type="checkbox"/> Not done                     </td> </tr> <tr> <td>Other antimicrobial (specify): _____</td> <td> <input type="checkbox"/> Susceptible   <input type="checkbox"/> Intermediate   <input type="checkbox"/> Resistant   <input type="checkbox"/> Not done                     </td> </tr> </table>	Ampicillin:	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done	Azithromycin:	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done	Ciprofloxacin:	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done	TMP-SMX:	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done	Third-generation cephalosporin (specify): _____	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done	Other antimicrobial (specify): _____	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done
Ampicillin:	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done												
Azithromycin:	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done												
Ciprofloxacin:	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done												
TMP-SMX:	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done												
Third-generation cephalosporin (specify): _____	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done												
Other antimicrobial (specify): _____	<input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done												

**CLINICAL LABORATORY RESULTS – Other Tests for Enteric Diagnosis (e.g., serology or mixed enteric infection)**

<i>Specimen Type 1</i>	<i>Type of Test (include non-culture diagnostic testing results)</i>	<i>Test Results</i>		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><i>Collection Date (mm/dd/yyyy)</i></td> <td><i>Laboratory Name</i></td> </tr> </table>	<i>Collection Date (mm/dd/yyyy)</i>	<i>Laboratory Name</i>	<i>Telephone Number</i>
<i>Collection Date (mm/dd/yyyy)</i>	<i>Laboratory Name</i>			
<i>Specimen Type 2</i>	<i>Type of Test (include non-culture diagnostic testing results)</i>	<i>Test Results</i>		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><i>Collection Date (mm/dd/yyyy)</i></td> <td><i>Laboratory Name</i></td> </tr> </table>	<i>Collection Date (mm/dd/yyyy)</i>	<i>Laboratory Name</i>	<i>Telephone Number</i>
<i>Collection Date (mm/dd/yyyy)</i>	<i>Laboratory Name</i>			

**CDPH MICROBIAL DISEASES LABORATORY (MDL) OR OTHER REFERENCE PUBLIC HEALTH LABORATORY (PHL) RESULTS**

**\*\*\*Please enter final confirmatory results if available.\*\*\***

Was isolate or broth forwarded to a local public health lab? (required field) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Local Lab ID Number</i>
Was isolate or broth forwarded to MDL? (required field) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>State Lab ID Number</i>
Specimen Type <input type="checkbox"/> Stool <input type="checkbox"/> Other (specify): _____	<i>Collection Date (mm/dd/yyyy)</i>

**SHIGA TOXIN RESULTS**

Shiga Toxin Test Result (required field) <input type="checkbox"/> Stx positive <input type="checkbox"/> Stx negative <input type="checkbox"/> Unk	If Stx positive, specify type of toxin(s) or toxin genes <input type="checkbox"/> Stx 1 <input type="checkbox"/> Stx 2 <input type="checkbox"/> Stx 1 and Stx 2 <input type="checkbox"/> Cytopathic effect <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____
Type of Shiga Toxin Test <input type="checkbox"/> Enzyme immunoassay (EIA) <input type="checkbox"/> PCR <input type="checkbox"/> Vero cell assay <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____	Laboratory Name <input type="checkbox"/> MDL <input type="checkbox"/> PHL: _____

**STOOL CULTURES**

Culture Result (required field) <input type="checkbox"/> <i>E. coli</i> O157 <input type="checkbox"/> STEC non-O157 <input type="checkbox"/> Not done <input type="checkbox"/> Negative <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 90%;">                             If <i>E. coli</i> O157, specify flagellar (H) antigen  <input type="checkbox"/> H7   <input type="checkbox"/> Non-motile   <input type="checkbox"/> Unk   <input type="checkbox"/> Not done                         </td> <td style="width: 10%;"></td> </tr> <tr> <td colspan="2">                             If STEC non-O157, specify serogroup  <input type="checkbox"/> O26   <input type="checkbox"/> O103   <input type="checkbox"/> O121   <input type="checkbox"/> <i>E. coli</i> not O26, O103, O111, O121, O145, or O157 (O-Undetermined)  <input type="checkbox"/> O45   <input type="checkbox"/> O111   <input type="checkbox"/> O145   <input type="checkbox"/> Other (specify): _____                         </td> </tr> <tr> <td colspan="2">                             If STEC non-O157 and H antigen identified, specify H antigen  <input type="checkbox"/> Non-motile   <input type="checkbox"/> Other: _____                         </td> </tr> <tr> <td style="width: 70%;"><i>Laboratory Name</i></td> <td><i>Telephone Number</i></td> </tr> </table>	If <i>E. coli</i> O157, specify flagellar (H) antigen <input type="checkbox"/> H7 <input type="checkbox"/> Non-motile <input type="checkbox"/> Unk <input type="checkbox"/> Not done		If STEC non-O157, specify serogroup <input type="checkbox"/> O26 <input type="checkbox"/> O103 <input type="checkbox"/> O121 <input type="checkbox"/> <i>E. coli</i> not O26, O103, O111, O121, O145, or O157 (O-Undetermined) <input type="checkbox"/> O45 <input type="checkbox"/> O111 <input type="checkbox"/> O145 <input type="checkbox"/> Other (specify): _____		If STEC non-O157 and H antigen identified, specify H antigen <input type="checkbox"/> Non-motile <input type="checkbox"/> Other: _____		<i>Laboratory Name</i>	<i>Telephone Number</i>
If <i>E. coli</i> O157, specify flagellar (H) antigen <input type="checkbox"/> H7 <input type="checkbox"/> Non-motile <input type="checkbox"/> Unk <input type="checkbox"/> Not done									
If STEC non-O157, specify serogroup <input type="checkbox"/> O26 <input type="checkbox"/> O103 <input type="checkbox"/> O121 <input type="checkbox"/> <i>E. coli</i> not O26, O103, O111, O121, O145, or O157 (O-Undetermined) <input type="checkbox"/> O45 <input type="checkbox"/> O111 <input type="checkbox"/> O145 <input type="checkbox"/> Other (specify): _____									
If STEC non-O157 and H antigen identified, specify H antigen <input type="checkbox"/> Non-motile <input type="checkbox"/> Other: _____									
<i>Laboratory Name</i>	<i>Telephone Number</i>								

(continued on page 5)

First three letters of patient's last name: 

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**CDPH MICROBIAL DISEASES LABORATORY (MDL) OR OTHER REFERENCE PUBLIC HEALTH LABORATORY (PHL) RESULTS**  
**\*\*\*Please enter final results if available.\*\*\* (continued)**

**MOLECULAR DIAGNOSTICS**

Was PFGE completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	XbaI Pattern #	BlnI Pattern #	CDC Cluster ID #
Was MLVA completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify results		Laboratory Name <input type="checkbox"/> MDL <input type="checkbox"/> PHL: _____
Was whole genomic sequencing (WGS) completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, WGS ID #	Specify results or attach	Laboratory Name <input type="checkbox"/> MDL <input type="checkbox"/> PHL: _____

**EPIDEMIOLOGIC INFORMATION**

**INCUBATION PERIOD: 7 DAYS PRIOR TO ILLNESS ONSET**

**TRAVEL HISTORY**

Did patient travel <b>outside county of residence</b> during the <b>incubation period</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates below.
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**TRAVEL HISTORY – DETAILS**

Travel Type	Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
<input type="checkbox"/> Domestic <input type="checkbox"/> Unk <input type="checkbox"/> International			
<input type="checkbox"/> Domestic <input type="checkbox"/> Unk <input type="checkbox"/> International			
<input type="checkbox"/> Domestic <input type="checkbox"/> Unk <input type="checkbox"/> International			

**FOOD HISTORY - OUTSIDE HOME**

Did patient consume food or drink prepared outside of the home during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify name of place (e.g., restaurant, concession stand, friend's house, etc.), location, date, and items consumed below.
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**FOOD HISTORY - OUTSIDE HOME – DETAILS (Include restaurants, parties, take out, food trucks, etc.)**

Name of Place 1	Location (city, state)	Date (mm/dd/yyyy)
	Items Consumed	
Name of Place 2	Location (city, state)	Date (mm/dd/yyyy)
	Items Consumed	
Name of Place 3	Location (city, state)	Date (mm/dd/yyyy)
	Items Consumed	
Name of Place 4	Location (city, state)	Date (mm/dd/yyyy)
	Items Consumed	

First three letters of patient's last name:

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**FOOD HISTORY – GROCERIES**

**WHERE DID THE PATIENT SHOP FOR GROCERIES CONSUMED DURING THE INCUBATION PERIOD (INCLUDE GROCERY AND WAREHOUSE STORES, AS WELL AS FARMERS' MARKETS, DELIS, SWAP MEETS, ETC.)?**

Store / Location 1	Address / Cross-streets	
	City	State
Store / Location 2	Address / Cross-streets	
	City	State
Store / Location 3	Address / Cross-streets	
	City	State
Store / Location 4	Address / Cross-streets	
	City	State

**FOOD HISTORY (For all "Yes" responses, please prompt for details as specified.)**

**DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?**

Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Raw (unpasteurized) milk produced by a certified raw milk dairy				Type(s) e.g., cow, goat	Brand(s)	Where purchased
Raw milk from other sources (e.g., directly from farm or cow)				Type(s)	Describe	Location
Other raw milk products such as colostrum, cream, kefir, cheese				Type(s) of product	Describe (e.g., brand, etc.)	Where purchased
Mexican-style cheese (e.g., queso fresco, panela)				Source <input type="checkbox"/> Store-bought <input type="checkbox"/> Street vendor/door-to-door <input type="checkbox"/> Homemade <input type="checkbox"/> Other: _____		Where purchased
				Was the cheese unpasteurized (raw)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Brand(s)	
Artisanal or gourmet cheese (These are often cheeses that are cut and packaged on-site at cheese shops, cheese counters at grocery stores, and farmers' markets.)				Type(s)	Brand(s)	Where purchased
Ground beef (e.g., hamburger, meatballs, meatloaf, pasta, etc.) <u>eaten or handled in the home</u>				Purchased in bulk (e.g., chub, plastic wrapped on styrofoam container)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was the bulk ground beef eaten undercooked or raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Where purchased
					Brand(s)	
				Purchased as preformed patties? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Were the patties eaten undercooked or raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Where purchased
				Type(s)	Brand(s)	
Describe (include as much information as possible, including fresh or frozen, % lean, organic, # lbs purchased, etc.)						
Was the ground beef: (check all that apply) <input type="checkbox"/> Eaten <input type="checkbox"/> Handled <input type="checkbox"/> In home but not eaten or handled						

(continued on page 7)

First three letters of patient's last name: 

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<b>FOOD HISTORY (continued)</b>						
Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Ground beef <u>eaten outside the home</u> (e.g., restaurant)				<i>Eaten undercooked or raw?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>How was it served</i> <input type="checkbox"/> Hamburger <input type="checkbox"/> Other: _____	<i>Where purchased</i>
Beef steaks, stews, roasts eaten <u>at home</u>				<i>Eaten undercooked or raw?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<i>Where purchased</i>
				<i>Type(s)</i>	<i>Brand(s)</i>	
Beef steaks, stews, roasts eaten <u>outside the home</u> (e.g., restaurant)				<i>Eaten undercooked or raw?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<i>Where purchased</i>
				<i>Type(s)</i>	<i>Brand(s)</i>	
Bison, venison, or other game meat				<i>Type(s)</i>	<i>Brand(s)</i>	<i>Where purchased</i>
Dried or fermented meat (e.g., salami, pepperoni, jerky, summer sausage)				<i>Type(s)</i>	<i>Brand(s)</i>	<i>Where purchased</i>
Meat (hogs, cows, etc.) slaughtered at home or at a live animal market				<i>Type(s)</i>	<i>Describe</i>	<i>Where purchased</i>
Pork <u>prepared at home</u> (e.g., whole pig, chops, tenderloin, roast, shoulder, ground, etc.)				<i>Type(s)</i> / <i>Cut(s)</i>	<i>Brand(s)</i>	<i>Where purchased</i>
Pork prepared <u>outside the home</u> (e.g., pig roasts, sit-down and fast food restaurants, food trucks, cafeterias, etc.)				<i>Place name(s)</i>		
				<i>Dish(es)</i>		
Iceberg lettuce <u>at home</u> , such as whole leaf or shredded in salad, on a burger or sandwich				<i>How was it packaged</i> <input type="checkbox"/> Head of lettuce <input type="checkbox"/> Prepackaged <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____		<i>Where purchased</i>
				<i>If Prepackaged, type of container</i> <input type="checkbox"/> Bag <input type="checkbox"/> Clamshell <input type="checkbox"/> Other: _____		
				<i>Brand(s)</i>	<i>Organic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Iceberg lettuce <u>away from home</u> , such as whole leaf or shredded in salad, on a burger or sandwich				<i>How served (e.g., in a salad, shredded on a burger, etc.)</i>		<i>Where eaten</i>
Romaine lettuce <u>at home</u> , such as whole leaf or shredded in salad, on a burger or sandwich				<i>How was it packaged</i> <input type="checkbox"/> Loose <input type="checkbox"/> Prepackaged <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____		<i>Where purchased</i>
				<i>If Prepackaged, type of container</i> <input type="checkbox"/> Bag <input type="checkbox"/> Clamshell <input type="checkbox"/> Other: _____		
				<i>Brand(s)</i>	<i>Organic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Romaine lettuce <u>away from home</u> , such as whole leaf or shredded in salad, on a burger or sandwich				<i>How served (e.g., in a salad, shredded on a burger, etc.)</i>		<i>Where eaten</i>
Spinach <u>at home</u> , such as whole leaf or shredded in salad, in a burger or sandwich, or in a smoothie				<i>How was it packaged</i> <input type="checkbox"/> Loose <input type="checkbox"/> Prepackaged <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____		<i>Where purchased</i>
				<i>If Prepackaged, type of container</i> <input type="checkbox"/> Bag <input type="checkbox"/> Clamshell <input type="checkbox"/> Other: _____		
				<i>Brand(s)</i>	<i>Organic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Spinach <u>away from home</u> , such as whole leaf or shredded in salad, in a burger or sandwich, or in a smoothie				<i>How served (e.g., in a salad, on a burger/sandwich, in a smoothie, etc.)</i>		<i>Where eaten</i>

(continued on page 8)

First three letters of patient's last name: 

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<b>FOOD HISTORY (continued)</b>						
Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Other leafy greens (e.g., cabbage, kale, red leaf lettuce, mesclun, chard, arugula, etc.)				<i>Describe</i>		
				<i>How was it packaged</i> <input type="checkbox"/> Loose <input type="checkbox"/> Prepackaged <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	<i>Where purchased</i>	
				<i>If Prepackaged, type of container</i> <input type="checkbox"/> Bag <input type="checkbox"/> Clamshell <input type="checkbox"/> Other: _____		
				<i>Brand(s)</i> <span style="float: right;"><i>Organic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</span>		
Any prepackaged salads (these are ready-to-eat salads with toppings, meats, dressing), including those sold in a bag or plastic container				<i>Describe type of salad (e.g., ingredients, single or multiple serving, etc.)</i>		
				<i>Type of container</i> <input type="checkbox"/> Bag <input type="checkbox"/> Clamshell <input type="checkbox"/> Other: _____	<i>Where purchased</i>	
				<i>Brand(s)</i> <span style="float: right;"><i>Organic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</span>		
Raw sprouts, such as from a salad bar, sandwich, stir fry, etc.				<i>Type(s)</i> <input type="checkbox"/> Alfalfa sprouts <input type="checkbox"/> Broccoli sprouts <input type="checkbox"/> Mixed sprouts <input type="checkbox"/> Other: _____ <input type="checkbox"/> Bean sprouts <input type="checkbox"/> Clover sprouts <input type="checkbox"/> Radish (daikon) sprouts <input type="checkbox"/> Unk		
				<i>Brand(s)</i>	<i>Where purchased</i>	
Other raw vegetables				<i>Type(s)</i>	<i>Where purchased</i>	
Strawberries				<i>Brand(s)</i>	<i>Where purchased</i>	
Other fresh fruit				<i>Type(s)</i>	<i>Where purchased</i>	
Unpasteurized juice or cider				<i>Type(s)</i>	<i>Brand(s)</i>	<i>Where purchased</i>
Smoothies/juices				<i>Where prepared</i> <input type="checkbox"/> At home <input type="checkbox"/> Outside the home (place): _____ <input type="checkbox"/> Other: _____		
				<i>Specify ingredients, including any leafy greens, vegetables, fruits, nuts, seeds, protein powders, dairy/milk, other supplements</i>		
Uncooked or unbaked dough or batter (such as cookie, cake, biscuit, and muffin batter)				<i>Type of dough or batter</i> <input type="checkbox"/> Premade <input type="checkbox"/> Homemade from prepackaged mix <input type="checkbox"/> Homemade from scratch <input type="checkbox"/> Other: _____		
				<i>Brand of flour or baking mix used</i>		
Nuts				<i>Type(s)</i> <input type="checkbox"/> Almonds <input type="checkbox"/> Hazelnuts <input type="checkbox"/> Walnuts <input type="checkbox"/> Unk <input type="checkbox"/> Cashews <input type="checkbox"/> Peanuts <input type="checkbox"/> Other: _____	<i>Where purchased</i>	
Untreated water				<i>Source(s)</i>		
Any specialty or ethnic foods or snacks				<i>Food item(s)</i>	<i>Where purchased</i>	
Other food items of interest				<i>Food item(s)</i>	<i>Where purchased</i>	
Any food allergies or dietary restrictions				<i>Describe</i>		



First three letters of patient's last name: 

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**EVENTS OR ACTIVITIES**

**DID THE PATIENT ATTEND OR PARTICIPATE IN ANY OF THE FOLLOWING EVENTS OR ACTIVITIES DURING THE INCUBATION PERIOD?**

Event / Activity	Yes	No	Unk	If Yes, Specify as Noted
Recreational water (e.g., pools, water parks, interactive fountain)				Location
Untreated recreational water (e.g., lakes, ocean)				Location
Ranches, farms, or livestock raising/processing sites				Location
Animal exhibits (e.g., petting zoos, fairs)				Location
Other activities of interest				Describe

**WAS THE PATIENT EMPLOYED IN (OR SPENT SIGNIFICANT TIME IN) ANY OF THE FOLLOWING ACTIVITIES DURING THE INCUBATION PERIOD?**

Work with animals or animal products				Describe
Contact with children in day care				Describe
Other exposures of interest				Describe

**PATIENT CLEARANCE INFORMATION**

Did this patient require clearance to return to daycare, school or work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, please provide clearance details below.	
Was clearance completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of First Clearance Specimen (mm/dd/yyyy)		If Yes, Date of Final Clearance Specimen (mm/dd/yyyy)
	If No, specify reason		
Clearance Issues (including use of antibiotics to facilitate clearance, etc.) / Comments			

**PATIENT EMPLOYMENT/SITUATION INFORMATION FOR CLEARANCE**

Employer/Situation 1 (place of employment, daycare name, etc.)		Telephone Number	
Street Address	City	State	Zip Code
Employer/Situation 2 (place of employment, daycare name, etc.)		Telephone Number	
Street Address	City	State	Zip Code

**HOUSEHOLD CONTACTS**

How many people besides the case live in the household? Please provide details below.

**HOUSEHOLD CONTACTS – DETAILS**

Name 1	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 2	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment

(continued on page 10)

First three letters of patient's last name: 

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**HOUSEHOLD CONTACTS – DETAILS (continued)**

Name 3	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 4	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment

**ILL CONTACTS**

Any contacts with similar illness (including household contacts)?  
 Yes  No  Unk If Yes, specify details below.

**ILL CONTACTS – DETAILS**

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)	
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)	
	City		State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Laboratory confirmed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			CalREDIE ID (if applicable)		
Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)	
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)	
	City		State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Laboratory confirmed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			CalREDIE ID (if applicable)		

**NOTES / REMARKS**

**REPORTING AGENCY**

Investigator Name	Local Health Jurisdiction	Telephone Number	Date Form Completed (mm/dd/yyyy)
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____		Health education provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Patient restriction / clearance needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

**EPIDEMIOLOGICAL LINKAGE**

Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number
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**DISEASE CASE CLASSIFICATION**

Case Classification (see case definition below)  
 Confirmed  Probable  Suspect

First three letters of patient's last name: 

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<b>OUTBREAK</b>			
<i>Part of known outbreak?</i>	<i>If Yes, extent of outbreak:</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
<i>Mode of Transmission</i>	<i>Vehicle of Outbreak</i>	<i>Pattern 1 ID number</i>	<i>Pattern 2 ID number</i>
<input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____			
<b>STATE USE ONLY</b>			
<i>State Case Classification</i>			
<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information			
<b>CASE DEFINITION</b>			
<b><u>SHIGA TOXIN-PRODUCING <i>ESCHERICHIA COLI</i> (STEC) (2018)</u></b>			
<b>BACKGROUND</b>			
Shiga-toxin producing <i>Escherichia coli</i> (STEC), also referred to as Enterohemorrhagic <i>E. coli</i> (EHEC), can cause illness that ranges from mild diarrhea to bloody diarrhea and life-threatening hemolytic uremic syndrome (HUS). STEC are categorized into serogroups by their somatic O antigen. The STEC serogroup most commonly identified and associated with severe illness in the United States is <i>E. coli</i> O157; however, there are over 50 other serogroups that can cause illness.			
<b>CLINICAL CRITERIA</b>			
An infection of variable severity characterized by diarrhea (often bloody) and/or abdominal cramps. Illness may be complicated by HUS (note that some clinicians still use the term thrombotic thrombocytopenic purpura [TTP] for adults with post-diarrheal HUS).			
<b>LABORATORY CRITERIA FOR DIAGNOSIS</b>			
<b>Confirmatory laboratory evidence</b>			
<ul style="list-style-type: none"> <li>• Isolation of <i>E. coli</i> O157:H7 from a clinical specimen, OR</li> <li>• Isolation of <i>E. coli</i> from a clinical specimen with detection of Shiga toxin or Shiga toxin genes.</li> </ul>			
<b>Supportive laboratory evidence</b>			
<ul style="list-style-type: none"> <li>• Isolation of <i>E. coli</i> O157 from a clinical specimen without confirmation of H antigen, detection of Shiga toxin, or detection of Shiga toxin genes, OR</li> <li>• Identification of an elevated antibody titer against a known Shiga toxin-producing serogroup of <i>E. coli</i>, OR</li> <li>• Detection of Shiga toxin or Shiga toxin genes in a clinical specimen using a culture-independent diagnostic test (CIDT) and no known isolation of <i>Shigella</i> from a clinical specimen, OR</li> <li>• Detection of <i>E. coli</i> O157 or STEC/EHEC in a clinical specimen using a CIDT.</li> </ul>			
<b>EPIDEMIOLOGIC LINKAGE</b>			
<ul style="list-style-type: none"> <li>• A clinically compatible illness in a person that is epidemiologically linked to a confirmed or probable case with laboratory evidence, OR</li> <li>• A clinically compatible illness in a person that is a member of a risk group as defined by public health authorities during an outbreak.</li> </ul>			
<b>Criteria to distinguish a new case of this disease or condition from reports or notifications which should not be enumerated as a new case for surveillance:</b>			
<ul style="list-style-type: none"> <li>• A new case should be created when a positive laboratory result is received more than 180 days after the most recent positive laboratory result associated with a previously reported case in the same individual, OR</li> <li>• When two or more different serogroups/serotypes are identified in one or more specimens from the same individual, each serogroup/serotype should be reported as a separate case.</li> </ul>			
<b>CASE CLASSIFICATION</b>			
<b>Confirmed</b>			
<ul style="list-style-type: none"> <li>• A person that meets the confirmatory laboratory criteria for diagnosis.</li> </ul>			
<b>Probable</b>			
<ul style="list-style-type: none"> <li>• A person with isolation of <i>E. coli</i> O157 from a clinical specimen without confirmation of H antigen, detection of Shiga toxin or detection of Shiga toxin genes, OR</li> <li>• A clinically compatible illness in a person with identification of an elevated antibody titer against a known Shiga toxin-producing serogroup of <i>E. coli</i>, OR</li> <li>• A clinically compatible illness in a person with detection of Shiga toxin or Shiga toxin genes in a clinical specimen using a CIDT and no known isolation of <i>Shigella</i> from a clinical specimen, OR</li> <li>• A clinically compatible illness in a person with detection of <i>E. coli</i> O157 or STEC/EHEC from a clinical specimen using a CIDT, OR</li> <li>• A clinically compatible illness in a person that is epidemiologically linked to a confirmed or probable case with laboratory evidence, OR</li> <li>• A clinically compatible illness in a person that is a member of a risk group as defined by public health authorities during an outbreak.</li> </ul>			
<b>Suspect</b>			
<ul style="list-style-type: none"> <li>• A person that meets the supportive laboratory criteria for diagnosis with no known clinical compatibility, OR</li> <li>• A person with a diagnosis of post-diarrheal HUS/TTP (see HUS case definition).</li> </ul>			

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**CASE DEFINITION (continued)****SHIGA TOXIN-PRODUCING ESCHERICHIA COLI (STEC) (2018)** (continued)**COMMENTS**

Asymptomatic infections and infections at sites other than the gastrointestinal tract in people (1) meeting the confirmatory laboratory criteria for diagnosis or (2) with isolation of *E. coli* O157 from a clinical specimen without confirmation of H antigen, detection of Shiga toxin, or detection of Shiga toxin genes, are considered STEC cases and should be reported.

Although infections with Shiga toxin-producing organisms in the United States are primarily caused by STEC, in recent years an increasing number are due to infections by Shiga toxin-producing *Shigella*. Persons with (1) detection of Shiga toxin or Shiga toxin genes using a CIDT and (2) isolation of *Shigella spp.* from a clinical specimen should not be reported as an STEC case.

Due to the variable sensitivities and specificities of CIDT methods and the potential for degradation of Shiga toxin in a specimen during transit, discordant results may occur between clinical and public health laboratories. Persons with (1) detection of Shiga toxin or Shiga toxin genes using a CIDT, (2) the absence of isolation of *Shigella* from a clinical specimen, and (3) clinically compatible symptoms, should be reported as a probable case, regardless of whether detection of Shiga toxin or Shiga toxin genes is confirmed by a public health laboratory.

**HEMOLYTIC UREMIC SYNDROME, POST-DIARRHEAL (2010)****CLINICAL DESCRIPTION**

Hemolytic uremic syndrome (HUS) is characterized by the acute onset of microangiopathic hemolytic anemia, renal injury, and low platelet count. Thrombotic thrombocytopenic purpura (TTP) also is characterized by these features but can include central nervous system (CNS) involvement and fever and may have a more gradual onset. Most cases of HUS (but few cases of TTP) occur after an acute gastrointestinal illness (usually diarrheal).

**LABORATORY CRITERIA FOR DIAGNOSIS**

The following are both present at some time during the illness: Anemia (acute onset) with microangiopathic changes (i.e., schistocytes, burr cells, or helmet cells) on peripheral blood smear and renal injury (acute onset) evidenced by either hematuria, proteinuria, or elevated creatinine level (i.e., greater than or equal to 1.0 mg/dL in a child aged less than 13 years or greater than or equal to 1.5 mg/dL in a person aged greater than or equal to 13 years, or greater than or equal to 50% increase over baseline).

Note: A low platelet count can usually, but not always, be detected early in the illness, but it may then become normal or even high. If a platelet count obtained within 7 days after onset of the acute gastrointestinal illness is not less than 150,000/mm<sup>3</sup>, other diagnoses should be considered.

**CASE CLASSIFICATION****Confirmed**

- An acute illness diagnosed as HUS or TTP that both meets the laboratory criteria and began within 3 weeks after onset of an episode of acute or bloody diarrhea

**Probable**

- An acute illness diagnosed as HUS or TTP that meets the laboratory criteria in a patient who does not have a clear history of acute or bloody diarrhea in preceding 3 weeks, OR
- An acute illness diagnosed as HUS or TTP, that a) has onset within 3 weeks after onset of an acute or bloody diarrhea and b) meets the laboratory criteria except that microangiopathic changes are not confirmed

**COMMENT**

Some investigators consider HUS and TTP to be part of a continuum of disease. Therefore, criteria for diagnosing TTP on the basis of CNS involvement and fever are not provided because cases diagnosed clinically as post-diarrheal TTP also should meet the criteria for HUS. These cases are reported as post-diarrheal HUS.

<b>RACE DESCRIPTIONS</b>	
<b>Race</b>	<b>Description</b>
American Indian or Alaska Native	Patient has origins in <b>any</b> of the original peoples of North and South America (including Central America).
Asian	Patient has origins in <b>any</b> of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in <b>any</b> of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in <b>any</b> of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in <b>any</b> of the original peoples of Europe, the Middle East, or North Africa.
<b>OCCUPATION SETTING</b>	
<ul style="list-style-type: none"> <li>• Childcare/Preschool</li> <li>• Correctional Facility</li> <li>• Drug Treatment Center</li> <li>• Food Service</li> <li>• Health Care - Acute Care Facility</li> <li>• Health Care - Long Term Care Facility</li> <li>• Health Care - Other</li> </ul>	<ul style="list-style-type: none"> <li>• Homeless Shelter</li> <li>• Laboratory</li> <li>• Military Facility</li> <li>• Other Residential Facility</li> <li>• Place of Worship</li> <li>• School</li> <li>• Other</li> </ul>
<b>OCCUPATION</b>	
<ul style="list-style-type: none"> <li>• Adult film actor/actress</li> <li>• Agriculture - farmworker or laborer (crop, nursery, or greenhouse)</li> <li>• Agriculture - field worker</li> <li>• Agriculture - migratory/seasonal worker</li> <li>• Agriculture - other/unknown</li> <li>• Animal - animal control worker</li> <li>• Animal - farm worker or laborer (farm or ranch animals)</li> <li>• Animal - veterinarian or other animal health practitioner</li> <li>• Animal - other/unknown</li> <li>• Clerical, office, or sales worker</li> <li>• Correctional facility - employee</li> <li>• Correctional facility - inmate</li> <li>• Craftsman, foreman, or operative</li> <li>• Daycare or child care attendee</li> <li>• Daycare or child care worker</li> <li>• Dentist or other dental health worker</li> <li>• Drug dealer</li> <li>• Fire fighting or prevention worker</li> <li>• Flight attendant</li> <li>• Food service - cook or food preparation worker</li> <li>• Food service - host or hostess</li> <li>• Food service - server</li> <li>• Food service - other/unknown</li> <li>• Homemaker</li> <li>• Laboratory technologist or technician</li> <li>• Laborer - private household or unskilled worker</li> <li>• Manager, official, or proprietor</li> <li>• Manicurist or pedicurist</li> <li>• Medical - emergency medical technician or paramedic</li> <li>• Medical - health care worker</li> </ul>	<ul style="list-style-type: none"> <li>• Medical - medical assistant</li> <li>• Medical - pharmacist</li> <li>• Medical - physician assistant or nurse practitioner</li> <li>• Medical - physician or surgeon</li> <li>• Medical - nurse</li> <li>• Medical - other/unknown</li> <li>• Military</li> <li>• Police officer</li> <li>• Professional, technical, or related profession</li> <li>• Retired</li> <li>• Sex worker</li> <li>• Stay at home parent/guardian</li> <li>• Student - preschool or kindergarten</li> <li>• Student - elementary or middle school</li> <li>• Student - high school</li> <li>• Student - college or university</li> <li>• Student - other/unknown</li> <li>• Teacher/employee - preschool or kindergarten</li> <li>• Teacher/employee - elementary or middle school</li> <li>• Teacher/employee - high school</li> <li>• Teacher/instructor/employee - college or university</li> <li>• Teacher/instructor/employee - other/unknown</li> <li>• Unemployed - seeking employment</li> <li>• Unemployed - not seeking employment</li> <li>• Unemployed - other/unknown</li> <li>• Volunteer</li> <li>• Other</li> <li>• Refused</li> <li>• Unknown</li> </ul>