

Escherichia coli Surveillance Report Form

Please complete all questions and fax to: Infectious Disease Epidemiology at (504) 219 – 4522.

PATIENT DEMOGRAPHIC INFORMATION

1. Last name: _____ 2. First name: _____
3. DOB (mm/dd/yyyy): _____ 4. Age (years): _____ 5. Gender: M F
6. Address: _____
7. City: _____ 8. State: LA 9. Zip: _____ 10. Parish: _____
11. Home phone: ()- _____ 12. Work phone: ()- _____
13. Race/ Ethnicity: White Hispanic
 African American Non-Hispanic
 Asian/ Pacific Islander Unknown
 American Indian/ Alaska Native
 Unknown
 Other _____

ISOLATE/ LABORATORY TEST INFORMATION

14. Source of specimen: Stool Rectal Swab Blood Other: _____
15. Date of specimen collection (mm/dd/yyyy): _____
16. Serogroup: Escherichia coli 0157, if yes then is Serotype H7 confirmed: Yes No Unknown
 Escherichia coli non-0157
 Escherichia coli not grouped
17. Toxin: a) Shiga toxin Detected Not Detected Unknown
b) Heat stable enterotoxin Detected Not Detected Unknown
c) Heat labile enterotoxin Detected Not Detected Unknown
18. PFGE pattern: _____ 19. Multi-state pattern: Yes No Unknown
20. This case reported by: Hospital
 Private physician
 Private laboratory
 School
 Other _____
21. Physician's name: _____ Tel. no: () _____

CLINICAL INFORMATION

22. Date of illness onset (mm/dd/yyyy): _____
23. Was the patient hospitalized? Yes No Unknown
24. Name of hospital: _____
25. Date of hospitalization (mm/dd/yyyy): _____
26. Did the patient die? Yes No Unknown

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CLINICAL INFORMATION

27. Symptoms:	Yes	No	Unknown
Fever (Temp: _____ °F)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visible blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemolytic Uremic Syndrome (HUS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrombotic Thrombocytopenic Purpura (TTP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EPIDEMIOLOGICAL INFORMATION

28. Did the patient attend or work in a daycare? Yes No Unknown

If yes, where: _____

If yes, did patient change any diapers? Yes No Unknown

29. Does the patient usually work as: Yes No Unknown

a) Health care worker?

b) Food handler?

If yes, where: _____

30. In the 7 days before the illness began, did the patient eat or drink any of the following items?

	Yes	No	Unknown
Raw (unpasteurized) milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unchlorinated drinking water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apple Cider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ground beef or Hamburger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was it raw or rare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steak or Roast beef	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was it raw or rare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. In the 7 days before illness, did the patient eat at:

	Yes	No	Unknown
A fast-food restaurant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-fast food restaurant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, where: _____

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EPIDEMIOLOGICAL INFORMATION

32. In the 7 days before illness began, did the patient:

	Yes	No	Unknown
Swim in a lake, stream or river?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visit or live in a farm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have contact with any cattle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have contact with cow manure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Live or work in nursing home/ institution?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel to another state?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where? _____			
Travel to another country?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where? _____			

33. Did this case occur as part of an outbreak? Yes No Unknown

34. Does the patient know anyone else who had a similar illness in the 7 days before or after this patient's illness began? Yes No Unknown

If yes, please obtain names and telephone numbers of persons with similar illness:

Name: _____ Tel. no: () _____

Name: _____ Tel. no: () _____

Name: _____ Tel. no: () _____