Massachusetts Department of Public Health
Bureau of Communicable Disease Control
Office of Integrated Surveillance and Informatics Services (ISIS)
305 South Street, Jamaica Plain MA 02130
*Phone: **617-983-6801** Confidential Fax: **617-983-6813***

Received in ISIS:

HEMOLYTIC UREMIC SYNDROME

For assistance filling out this form, call (617) 983-6800

CONFIDENTIAL CASE REPORT

(leave this section blank for state health department use) Report Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Revoked

DEMOGRAPHIC INFORMATION

Last Name: First Name: MI:

Address: Apt. #:

City: State: Zip:

Unique Address Condition: ☐ Homeless ☐ Incarcerated

Contact Phone #:(_____) _____-_____ Occupation:

Birth date: _____/_____/_____ Place of birth (e.g. specific country):

Age: _____ ☐ Years ☐ Months ☐ Weeks ☐ Days ☐ Unk

Sex: ☐ Female ☐ Male ☐ Transgender ☐ Unk

Race *(check all that apply):*
☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unk

Hispanic: ☐ Yes ☐ No ☐ Unk

CLINICAL INFORMATION

Diagnosis date: _____/_____/_____

Did case have any symptoms? ☐ Yes ☐ No ☐ Unk Symptom onset date: _____/_____/_____

Abdominal cramps ☐ Yes ☐ No ☐ Unk Onset Date: ____/____/____

Acute renal dysfunction ☐ Yes ☐ No ☐ Unk

Anemia ☐ Yes ☐ No ☐ Unk

Diarrhea ☐ Yes ☐ No ☐ Unk

If yes: max. no. stools/24 hours:_____ Onset Date:____/____/____

Was diarrhea bloody? ☐ Yes ☐ No ☐ Unk Onset Date:____/____/____

Amount of blood in stool: ☐ None ☐ Gross blood ☐ Streaks

Fever ☐ Yes (highest temp:_____°F/°C) ☐ No ☐ Unk Onset Date: ____/____/____

Hematuria ☐ Yes ☐ No ☐ Unk Onset Date: ____/____/____

Lethargy ☐ Yes ☐ No ☐ Unk Onset Date: ____/____/____

Proteinuria ☐ Yes ☐ No ☐ Unk Onset Date: ____/____/____

Stool with mucous ☐ Yes ☐ No ☐ Unk

Thrombocytopenia ☐ Yes (lowest platelet count:_____) ☐ No ☐ Unk

Vomiting ☐ Yes ☐ No ☐ Unk Onset Date: ____/____/____

Other (*specify*):_____

Case hospitalized? ☐ Yes ☐ No ☐ Unk Date hospitalized: _____/_____/_____

Hospital name: Date discharged: _____/_____/_____

Outcome: ☐ Died ☐ Recovered ☐ Unk Date of death: _____/_____/_____

Clinician name and address:

Clinician phone #: (_____) _____-_____ Patient record/ chart #:

Was any antibiotic therapy administered for preceding diarrheal illness? ☐ Yes ☐ No ☐ Unk *If yes,*

Antibiotic_____Start date: _____/_____/_____ Stop date:_____/_____/_____

Antibiotic_____Start date: _____/_____/_____ Stop date:_____/_____/_____

Please complete page 2. Include additional lab information if available.

Did case undergo treatment? ☐ Yes *(select all that apply)* ☐ No ☐ Unk
☐ Hemodialysis Date: _____/_____/_____ ☐ Peritoneal dialysis Date: _____/_____/_____
☐ RBC transfusion Date: _____/_____/_____ ☐ Platelet transfusion Date: _____/_____/_____

Test type	Performed	Source	Collection Date	Interpretation	Result Value	Reference Range
BUN (blood urea nitrogen)	☐ Yes ☐ No ☐ Unk	☐ Blood ☐ CSF ☐ Urine ☐ Other_____	___/____/___	☐ Above normal range ☐ Below normal range ☐ Normal range ☐ Unk		
Creatinine level	☐ Yes ☐ No ☐ Unk	☐ Blood ☐ CSF ☐ Urine ☐ Other_____	___/____/___	☐ Above normal range* ☐ Below normal range ☐ Normal range ☐ Unk		
Hematocrit level	☐ Yes ☐ No ☐ Unk	☐ Blood ☐ CSF ☐ Urine ☐ Other_____	___/____/___	☐ Above normal range ☐ Below normal range ☐ Normal range ☐ Unk		
Microangiopathic changes (on peripheral blood smear)	☐ Yes ☐ No ☐ Unk	☐ Blood ☐ CSF ☐ Urine ☐ Other_____	___/____/___	☐ Schistocytes ☐ Burr cells ☐ Helmet cells ☐ Unk		

* Child: ≥ 1.0 mg/dl or ≥ 50% over baseline; Adult (> 12 years): ≥ 1.5 mg/kl or ≥ 50% over baseline

DIAGNOSTIC LABORATORY TEST INFORMATION

Was laboratory testing done? ☐ Yes ☐ No ☐ Unk Name of Laboratory: _____

Date specimen collected: _____/_____/_____ Organism identified: _____

Source: ☐ Stool ☐ Blood ☐ Other (*specify*): _____

Type of test: ☐ Culture ☐ Toxin ☐ PCR ☐ Other (*specify*): _____

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Other (*specify*): _____

INFORMATION RELEVANT TOEXPOSURE, CONTROL AND PREVENTION

Any recent travel? ☐ Yes ☐ No ☐ Unk If yes, when: _____/_____/_____to_____/_____/_____

Where to (*specify*): City: _____ State: _____ Country: _____

Is the case enrolled or employed at a supervised care center? ☐ Yes ☐ No ☐ Unk

If yes, select facility type: ☐ Daycare ☐ Long-term care facility Contact name:_____

Name and address of facility:_____

Is the case enrolled or employed at a school? ☐ Yes ☐ No ☐ Unk

If yes, name of school: _____ Contact name :_____Phone:(___) _____-_____

Is case a foodhandler? ☐ Yes ☐ No ☐ Unk

Place of employment: _____ Phone: (_____) _____-_____

ADMINISTRATIVE INFORMATION

Comments:_____

_____

Investigator's name: _____ Phone: (____) _____ - _____

Agency: _____ Fax: (____) _____ - _____

Date first reported to you: ___/___/___ Date investigation started: ___/___/___ Date form completed: ___/___/___

(Leave this section blank for state health department use)

Case report reviewed by epidemiologist? ☐ Yes Name: _____ Date reviewed: ___/___/___

Import Status: ☐ Unk ☐ Acquired in Massachusetts ☐ Acquired in USA outside MA ☐ Acquired outside USA
what state? _____ what country? _____

Is case part of a current outbreak? ☐ Yes ☐ No☐ Unk Outbreak name:_____