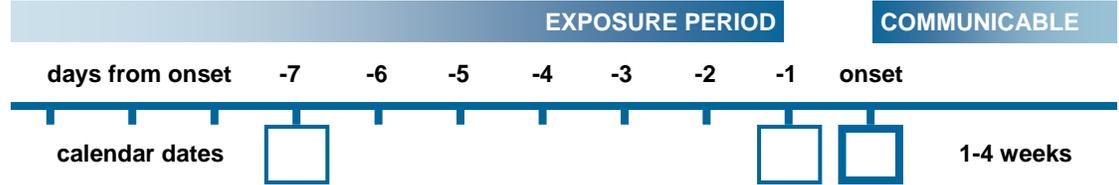


Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**INFECTION TIMELINE**

Enter onset date in heavy box. Count back to the figure probable exposure period. Ask about exposures between those dates.



**POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD**

Yes	No	Unk	Exposure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any ground beef or hamburger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, raw, rare or undercooked (pink)</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>In a home or private setting</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>In or from a sit-down or table service restaurant</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>In or from a fast food restaurant</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any steak or roast beef
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any venison or other wild game (e.g. elk, boar, pig, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any dried meat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, pepperoni, salami or summer sausage</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, jerky</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any other type of meat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any juices or ciders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, unpasteurized</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed raw cow's milk or other unpasteurized dairy products
			<i>If yes to raw milk,</i>
			Type/ place purchased: _____
			Date consumed: _____
			Date obtained: _____
			Available for testing: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any fresh lettuce
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, any bagged or pre-packaged</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any fresh spinach
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, any bagged or pre-packaged</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed any fresh or raw sprouts (e.g. alfalfa, clover, bean)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Group meal (e.g. potluck, reception, catered event)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consumed food from restaurants (e.g. dining in, take-out, drive-thru, leftovers)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have direct contact with a child who attends a child-care setting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attend or work in a residential facility or institution (e.g., jail, nursing home)

**PATIENT PROPHYLAXIS/TREATMENT**

Was the patient treated with any antibiotics for this illness?:  Yes  No  Unknown

*If yes, specify type, dose and dates given:*

Was the patient treated with any anti-diarrheals for this illness?:  Yes  No  Unknown

*If yes, specify type, dose and dates given:*

**OTHER CLINICAL DATA**

Has the patient been diagnosed with HUS/TTP?:  Yes  No  Unknown

## DRINKING WATER EXPOSURE

What is the source of tap water at home?:  do not use tap water  
 municipal, city or county  
 private well  
 other \_\_\_\_\_  
 unknown

If private well, how was the well water treated?: \_\_\_\_\_

What is the source of tap water at school/work?:  do not use tap water  
 municipal, city or county  
 private well  
 other \_\_\_\_\_  
 unknown

If private well, how was the well water treated?: \_\_\_\_\_

Did the patient drink untreated water in the 7 days prior to onset of illness?  Yes  No  Unknown

## RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the 7 days prior to illness?:  Yes  No  Unknown

What was the recreational water type?:  hot spring  hot tub—whirlpool—jacuzzi—spa  interactive fountain  
 lake—pond—river—stream  ocean  recreational water park  
 swimming pool (\_\_\_\_\_)  other (\_\_\_\_\_)  unknown

Name or location of water exposure: \_\_\_\_\_

## ANIMAL CONTACT

Did the patient live on a farm?  Yes  No  Unknown

Did the patient visit a farm or live animal exhibit (petting zoos, fairs, 4H, etc)?  Yes  No  Unknown

Did the patient come in contact with any animals?:  Yes  No  Unknown

If yes, type of animal?:  Cat  Cattle  Chicken  Dog  Goats  
 Lizard  Other  Other amphibian  Other mammal  Other reptile  
 Rodent  Sheep  Turkey  Turtle  Unknown

If other, other amphibian, other mammal or other reptile, please specify: \_\_\_\_\_

Name or Location of Animal Contact: \_\_\_\_\_

Did the patient acquire a pet prior to onset of illness?:  Yes  No  Unknown

## SUMMARY OF FOLLOW-UP

- Exclude from sensitive occupations (HCW, food, daycare) or situations until 2 negative stools
- Hygiene education provided
- Culture close contacts in sensitive occupations (HCW, food, daycare) or situations (daycare) regardless of symptom
- Restaurant inspection
- Initiate traceback investigation
- Daycare inspection
- Investigation of raw milk/dairy
- Other \_\_\_\_\_

## ALTERNATE CONTACT INFORMATION

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Relationship:  Parent  Spouse  
 Household Member  Friend  
Phone Number: \_\_\_\_\_  Other (\_\_\_\_\_)

## COMMENTS

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