

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

## E. COLI O157, OTHER STEC, SHIGA TOXIN POSITIVE FECES, AND/OR HUS CASE REPORT

- Check one:  *E. coli* O157 without HUS  Shiga toxin positive feces (without culture confirmation) without HUS  
 *E. coli* O157 with HUS  Shiga toxin positive feces (without culture confirmation) with HUS  
 STEC (non-O157) without HUS  Hemolytic Uremic Syndrome (HUS) without evidence of *E. coli* O157, other STEC, or Shiga toxin positive feces  
 STEC (non-O157) with HUS

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	
Address Number & Street - Residence		Apartment/Unit Number		<input type="checkbox"/> Spanish	
City/Town		State	Zip Code	<input type="checkbox"/> Other: _____	
Census Tract	County of Residence	Country of Residence		Ethnicity (check one)	
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)		<input type="checkbox"/> Hispanic/Latino	
Home Telephone	Cellular Phone/Pager	Work/School Telephone		<input type="checkbox"/> Non-Hispanic/Non-Latino	
E-mail Address		Other Electronic Contact Information		<input type="checkbox"/> Unk	
Work/School Location		Work/School Contact		Race* (check all that apply, race descriptions on page 9)	
Gender		Pregnant?		<input type="checkbox"/> African-American/Black	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<input type="checkbox"/> American Indian or Alaska Native	
Medical Record Number		Patient's Parent/Guardian Name		<input type="checkbox"/> Asian (check all that apply)	
Occupation Setting (see list on page 9)		Other Describe/Specify		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese	
Occupation (see list on page 9)		Other Describe/Specify		<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: _____	
				<input type="checkbox"/> Pacific Islander (check all that apply)	
				<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan	
				<input type="checkbox"/> Guamanian	
				<input type="checkbox"/> Other: _____	
				<input type="checkbox"/> White	
				<input type="checkbox"/> Other: _____	
				<input type="checkbox"/> Unk	

\*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.

### CLINICAL INFORMATION

Physician Name - Last Name	First Name	Telephone Number
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### GROUP SETTING

Attend child care or preschool? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Location / Other Details of Child Care, Preschool, or Skilled Nursing Facility
Live in skilled nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

First three letters of  
patient's last name:

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<b>SIGNS AND SYMPTOMS</b>					
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)		Date First Sought Medical Care (mm/dd/yyyy)	
Onset Time (hh:mm)		Specify AM/PM <input type="checkbox"/> AM <input type="checkbox"/> PM		Duration of Acute Symptoms (days)	
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted	
Diarrhea				Max. number of stools in 24-hr period	Onset date of diarrhea (mm/dd/yyyy)
Bloody diarrhea					
Fever				Highest temperature (specify °F/°C)	
Vomiting					
Abdominal cramps					
Other signs / symptoms (specify)					
<b>HEMOLYTIC UREMIC SYNDROME (HUS)</b>					
In order for a patient to be counted as a confirmed case of 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.					
Did patient have HUS (both anemia with microangiopathic changes and renal injury [hematuria, proteinuria, or elevated creatinine])? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			Did patient have TTP (HUS with central nervous system involvement)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Onset Date of HUS (mm/dd/yyyy)			Did patient have HUS or TTP that began within 3 weeks after onset of diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Did the patient require hemodialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			Did patient receive antimicrobial after onset of diarrhea but before onset of HUS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
<b>PAST MEDICAL HISTORY</b>					
Did the patient take an antimicrobial in the week prior to illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			If Yes, specify antimicrobial name		
Did the patient have other underlying conditions relevant to present illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			If Yes, specify type of condition		
Other (specify)					
<b>HOSPITALIZATION</b>					
Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, how many total hospital nights?	
If there were any ER or hospital stays related to this illness, specify details below.					
<b>HOSPITALIZATION - DETAILS</b>					
Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

(continued on page 3)

First three letters of  
patient's last name:

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<b>HOSPITALIZATION (continued)</b>					
Hospital Name 2		Street Address		Admit Date (mm/dd/yyyy)	
		City		Discharge / Transfer Date (mm/dd/yyyy)	
State	Zip Code	Telephone Number		Medical Record Number	Discharge Diagnosis
<b>SCHOOL / WORK ABSENCE</b>					
Did patient miss school or work because of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
<b>TREATMENT / MANAGEMENT</b>					
Received treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, specify the treatments below.			
<b>TREATMENT / MANAGEMENT DETAILS</b>					
Treatment Type 1 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other		Treatment Name		Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Treatment Type 2 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other		Treatment Name		Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
<b>TREATMENT / MANAGEMENT - SURGERY</b>					
Did patient undergo GI surgery for the illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			Details of the Surgery		
<b>OUTCOME</b>					
Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk		If Survived, Survived as of _____(mm/dd/yyyy)		Date of Death (mm/dd/yyyy)	
<b>LABORATORY INFORMATION</b>					
<b>E. coli O157:</b> In order for a case to be counted as confirmed for <i>E. coli</i> O157, the isolate associated with the case must have been identified as <i>E. coli</i> O157, and as either: 1) having an H7 flagellar antigen or H7 gene, or 2) as being a producer of Shiga toxin.					
<b>Other STEC (Shiga toxin producing E. coli):</b> In order for case to be counted as confirmed for STEC other than <i>E. coli</i> O157:H7, the isolate must have been identified as: 1) a non-O157 STEC serotype and 2) as being a producer of Shiga toxin. Common non-O157 STEC serotypes include: O103, O111, and O26. Usually the flagellar antigen will be identified on the same laboratory report as the serotype. Common serotypes along with their flagellar antigens are: O103:H2, O111:NM, and O26:H11.					
<b>Shiga toxin positive feces:</b> If no <i>E. coli</i> serotype has been identified, but patient's stool has tested positive for Shiga toxin, then a report of Shiga toxin positive feces should be made.					
<b>LABORATORY RESULTS SUMMARY - SHIGA TOXIN TESTS</b>					
Specimen Type <input type="checkbox"/> Stool <input type="checkbox"/> Other (specify): _____		Type of 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): _____			
Shiga Toxin Test Result <input type="checkbox"/> Stx positive <input type="checkbox"/> Stx negative <input type="checkbox"/> Unk		If Stx positive, specify type of toxin(s): <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): _____			
Collection Date (mm/dd/yyyy)		Laboratory Name		Telephone Number	
<b>LABORATORY RESULTS SUMMARY - STOOL CULTURES</b>					
Culture Result 1 <input type="checkbox"/> E. coli O157 <input type="checkbox"/> STEC non-O157 <input type="checkbox"/> Negative <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		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			Collection Date (mm/dd/yyyy)
		If STEC non-O157, specify serotype: <input type="checkbox"/> O26:H11 <input type="checkbox"/> O26:NM <input type="checkbox"/> O45:NM <input type="checkbox"/> O69:H11 <input type="checkbox"/> O103:H2 <input type="checkbox"/> O103:H11 <input type="checkbox"/> O111:NM <input type="checkbox"/> O112ab:H21 <input type="checkbox"/> O113:H21 <input type="checkbox"/> O118:H16 <input type="checkbox"/> O121:H19 <input type="checkbox"/> O123:H11 <input type="checkbox"/> O145:NM <input type="checkbox"/> Other (specify): _____			Laboratory Name
				Telephone Number	

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First three letters of patient's last name: 

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**LABORATORY RESULTS SUMMARY - STOOL CULTURES (continued)**

Culture Result 2 <input type="checkbox"/> E. coli O157 <input type="checkbox"/> STEC non-O157 <input type="checkbox"/> Negative <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____	If E. coli 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 serotype: <input type="checkbox"/> O26:H11 <input type="checkbox"/> O26:NM <input type="checkbox"/> O45:NM <input type="checkbox"/> O69:H11 <input type="checkbox"/> O103:H2 <input type="checkbox"/> O103:H11 <input type="checkbox"/> O111:NM <input type="checkbox"/> O112ab:H21 <input type="checkbox"/> O113:H21 <input type="checkbox"/> O118:H16 <input type="checkbox"/> O121:H19 <input type="checkbox"/> O123:H11 <input type="checkbox"/> O145:NM <input type="checkbox"/> Other (specify): _____	Collection Date (mm/dd/yyyy)  Laboratory Name  Telephone Number
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**LABORATORY RESULTS SUMMARY - OTHER TESTS**

<i>Specimen Type 1</i>	<i>Type of Test</i>	<i>Collection Date (mm/dd/yyyy)</i>	<i>Test Results</i>
	<i>Laboratory Name</i>		<i>Telephone Number</i>
<i>Specimen Type 2</i>	<i>Type of Test</i>	<i>Collection Date (mm/dd/yyyy)</i>	<i>Test Results</i>
	<i>Laboratory Name</i>		<i>Telephone Number</i>

**LABORATORY RESULTS SUMMARY - CONFIRMATION AND PFGE**

<i>Was result confirmed by local public health lab?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Result (including serotype)</i>	<i>Local Lab ID Number</i>
<i>Was isolate sent to state lab for serotyping confirmation?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Result (including serotype)</i>	<i>State Lab ID Number</i>
<i>Was PFGE requested?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Xbal Pattern #</i>	<i>BlnI Pattern #</i>
		<i>CDC Cluster ID #</i>

**EPIDEMIOLOGIC INFORMATION**

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

**FOOD HISTORY**

**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				Type(s)      Brand(s)      Where purchased
Raw milk products				Type(s)      Brand(s)      Where purchased
Untreated water				Source(s)
Ground beef				Eaten undercooked or raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk      Where purchased / eaten
Other beef				Type(s)      Eaten undercooked or raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk      Where purchased / eaten
Venison or other game meat				Type(s)
Dried meat (e.g., salami, jerky)				Type(s)      Brand(s)      Where purchased / eaten
Unpasteurized apple juice or cider				Type(s)      Brand(s)      Where purchased
Raw vegetables				Type(s)      Where purchased
Leafy green vegetables (e.g., spinach, lettuce)				Type(s)      Where purchased

(continued on page 5)

First three letters of patient's last name:

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**FOOD HISTORY (continued)**

**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	Where purchased
Raw sprouts (e.g., alfalfa, bean)				Type(s)	Where purchased
Other food items of interest				Food item(s)	Where purchased

**FOOD HISTORY - GROCERIES**

**WHERE DID PATIENT SHOP FOR GROCERIES? (INCLUDE FARMER'S 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

**FOOD HISTORY - OUTSIDE HOME**

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

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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**EVENTS OR ACTIVITIES**

<b>DID THE PATIENT ATTEND OR PARTICIPATE IN ANY OF THE FOLLOWING EVENTS OR ACTIVITIES DURING THE INCUBATION PERIOD?</b>				
Event / Activity	Yes	No	Unk	If Yes, Specify as Noted
Recreational water (e.g., swimming in lakes, oceans, pools, water parks)				Location
Livestock or farms				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

**TRAVEL HISTORY (INCUBATION PERIOD IS 7 DAYS PRIOR TO ILLNESS ONSET)**

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**

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

**HOUSEHOLD CONTACTS**

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

First three letters of patient's last name:

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**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
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

**NOTES / REMARKS**


**REPORTING AGENCY**

Investigator Name	Local Health Jurisdiction	Telephone Number	Date (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	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 on page 8)  
 Confirmed  Probable  Suspect

**OUTBREAK**

Part of known outbreak? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, extent of outbreak: <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): _____		
Mode of Transmission <input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	Vehicle of Outbreak	Pattern 1 ID number	Pattern 2 ID number

**STATE USE ONLY**

State Case Classification  
 Confirmed  Probable  Suspect  Not a case  Need additional information

**CASE DEFINITION****SHIGA TOXIN-PRODUCING *ESCHERICHIA COLI* (STEC) (2010)**

CLINICAL DESCRIPTION: An infection of variable severity characterized by diarrhea (often bloody) and abdominal cramps. Illness may be complicated by hemolytic uremic syndrome (HUS) or thrombotic thrombocytopenic purpura (TTP); asymptomatic infections also may occur and the organism may cause extraintestinal infections.

LABORATORY CRITERIA FOR DIAGNOSIS: Isolation of Shiga toxin-producing *Escherichia coli* from a clinical specimen. *E. coli* O157:H7 isolates may be assumed to be Shiga toxin-producing. For all other *E. coli* isolates, Shiga toxin production or the presence of Shiga toxin genes must be determined to be considered STEC.

## CASE CLASSIFICATION:

- **Confirmed:** A case that meets the laboratory criteria for diagnosis. When available, O and H antigen serotype characterization should be reported.
- **Probable:** A case with isolation of *E. coli* O157 from a clinical specimen, without confirmation of H antigen or Shiga toxin production, or a clinically compatible case that is epidemiologically linked to a confirmed or probable case, or identification of an elevated antibody titer to a known Shiga toxin-producing *E. coli* serotype from a clinically compatible case.
- **Suspect:** A case of post-diarrheal HUS or TTP (see HUS case definition), or identification of Shiga toxin in a specimen from a clinically compatible case without the isolation of the Shiga toxin-producing *E. coli*.

**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.

**SHIGA TOXIN DETECTED IN FECES. (CDHS 2006)**

LABORATORY CRITERIA FOR DIAGNOSIS: The presence of Shiga toxin detected from stool.

## CASE CLASSIFICATION:

- **Confirmed:** A case that meets the laboratory criteria for diagnosis.

<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>