

CASE ALERT FORM

Hemolytic Uremic Syndrome (HUS) Surveillance

NOTE: This alert form does not substitute for the case report form of *E. coli* O157/HUS Case Report Form (CDPH 8555). Please complete and submit the full *E. coli* O157/HUS Case Report Form when that information is available. This Case Alert Form is to be completed by the local health department.

Instructions: Complete the following by interviewing the attending physician and send/fax within 24 hours of suspected diagnosis to: CDPH/DCDC, 850 Marina Bay Pkwy, Bldg P, Room P2333, CA 94804-6403, Attention: Disease Investigations Section, FAX (510) 620-3425.

I. Patient Identification

Patient name—last	first	middle initial	Date of birth	Age	Sex
Parent/guardian—last	first		Medical record number		
Address—number, street	City	State	County	ZIP code	
Telephone number					
Home ()		Work ()			
RACE (check one)			ETHNICITY (check one)		
<input type="checkbox"/> African-American/Black <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____			<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
If Asian/Pacific Islander, please check one:					
<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Cambodian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Filipino	<input type="checkbox"/> Guamanian
<input type="checkbox"/> Japanese		<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Vietnamese
		<input type="checkbox"/> Other _____			

II. Hospital Information

Attending physician	Telephone number ()	Pager number ()	FAX number ()
Hospital			Still hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital record number	Date of admission or transfer to this facility (mm/dd/yy)	Date of discharge or transfer from this facility (mm/dd/yy)	
Institution transferred to (if applicable)		Institution where first hospitalized (if different)	
Date of initial hospitalization (if different) (mm/dd/yy)	Physician, initial hospitalization (if different)		Telephone number ()

III. Clinical Information

Date of HUS diagnosis (mm/dd/yy)	Did patient have diarrhea during three weeks before HUS diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	If yes, date of diarrhea onset (mm/dd/yy)
Did stools contain visible blood at any time? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Was diarrhea treated with antimicrobial medications before diagnosis of HUS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
Was an <i>E. coli</i> O157:H7 stool culture ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Name of laboratory that will culture the stool	
Was a verotoxin test ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Name of laboratory submitting stool to Microbial Diseases Laboratory	

Comments/notes

Local health department/person reporting case (print)	Date	Telephone number ()	FAX number ()
Agency name			