

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 _____
<i>(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)</i>
Report Status (check one)
<input type="checkbox"/> Preliminary <input type="checkbox"/> Final

SHIGELLOSIS CASE REPORT

Please complete this form for confirmed and probable cases of shigellosis. For case definitions, see pages 7 and 8. **Completion of this form is not required** but encouraged to improve surveillance of this disease. Jurisdictions not participating in CalREDIE should mail the completed form to IDB-SSS at the address above. Jurisdictions participating in CalREDIE should create a CalREDIE incident and enter the information directly into the CalREDIE system.

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

First three letters of
patient's last name:

--	--	--

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)	
Nausea					
Vomiting					
Abdominal cramps					

Other signs, symptoms, or complications, including reactive arthritis (specify)

HEMOLYTIC UREMIC SYNDROME (HUS)

In order for a patient to be counted as a confirmed case of post-diarrheal 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? (See case definition: includes 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	Onset Date of HUS (mm/dd/yyyy)	If patient had HUS, please obtain and attach medical records or upload to electronic filing cabinet.
---	--------------------------------	--

PAST MEDICAL HISTORY

Did the patient take antibiotics in the month prior to onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify antibiotic(s)
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(s)

HOSPITALIZATION

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.
--	--	---	--

HOSPITALIZATION – DETAILS

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
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

TREATMENT / MANAGEMENT

Received treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify the treatments below.
--	---------------------------------------

TREATMENT / MANAGEMENT – DETAILS

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)

First three letters of patient's last name:

--	--	--

OUTCOME

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)
--	---	----------------------------

LABORATORY INFORMATION

CLINICAL LABORATORY RESULTS – Culture and Culture Independent Diagnostic Testing [CIDT], including Shiga Toxin

Specimen Type <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other (specify): _____	Collection Date (mm/dd/yyyy)	
Clinical laboratory <i>Shigella</i> culture completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If culture completed, specify species (serogroup) <input type="checkbox"/> <i>S. dysenteriae</i> (Group A) <input type="checkbox"/> <i>S. boydii</i> (Group C) <input type="checkbox"/> Unspecified <input type="checkbox"/> <i>S. flexneri</i> (Group B) <input type="checkbox"/> <i>S. sonnei</i> (Group D) <input type="checkbox"/> Negative for <i>Shigella</i>	
<i>Shigella</i> CIDT identification completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If CIDT completed, specify result(s) <input type="checkbox"/> <i>Shigella</i> spp. <input type="checkbox"/> <i>Shigella</i> / Enteroinvasive <i>E. coli</i> (EIEC) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Negative for <i>Shigella</i>	
Shiga toxin test completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	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): _____	
Laboratory Name	Laboratory CLIA Number	Telephone Number

ANTIMICROBIAL SUSCEPTIBILITY TESTING

Antimicrobial susceptibility testing completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Ampicillin: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done Azithromycin: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done Ciprofloxacin: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done TMP-SMX: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done Third-generation cephalosporin (specify): _____ <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done
Attach additional results or upload to CalREDIE electronic filing cabinet.	

CDPH MICROBIAL DISEASES LABORATORY (MDL) OR OTHER REFERENCE PUBLIC HEALTH LABORATORY RESULTS
 Please enter final results if available

Specimen Type <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other (specify): _____	Collection Date (mm/dd/yyyy)		
Was <i>Shigella</i> isolate forwarded to a local public health lab? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Local Lab ID Number	Was isolate forwarded to MDL? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	State Lab ID Number
<i>Shigella</i> culture completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If culture completed, specify species (serogroup) <input type="checkbox"/> <i>S. dysenteriae</i> (Group A) <input type="checkbox"/> <i>S. boydii</i> (Group C) <input type="checkbox"/> Unspecified <input type="checkbox"/> <i>S. flexneri</i> (Group B) <input type="checkbox"/> <i>S. sonnei</i> (Group D) <input type="checkbox"/> Negative for <i>Shigella</i>		
	If serotyping completed, specify serotype <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Untypeable <input type="checkbox"/> Unk		

SHIGA TOXIN TESTS – SHIGELLA ISOLATE

Was <i>Shigella</i> isolate tested for Shiga toxin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type of Test (check all that apply) <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): _____	Laboratory Name <input type="checkbox"/> MDL <input type="checkbox"/> PHL: _____
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: _____	

MOLECULAR DIAGNOSTICS

Was PFGE completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Pattern 1 #	Pattern 2 #	CDC Cluster ID #
Was whole genome sequencing (WGS) completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify results		Laboratory Name <input type="checkbox"/> MDL <input type="checkbox"/> Reference PHL: _____

First three letters of patient's last name:

--	--	--

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 7 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY

Did patient travel **outside county of residence** during the **incubation period**? *If Yes, specify all locations and dates below.*
 Yes No Unk

TRAVEL HISTORY – DETAILS

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

GROUP SETTINGS & OTHER EXPOSURES	Yes	No	Unk	If Yes, Specify as Noted
---	-----	----	-----	---------------------------------

Exposure to a confirmed or probable shigellosis case				<i>Provide details in the Ill Contacts section below.</i>		
Attended or worked in daycare				<i>Location</i>		
Contact with a diapered child or adult				<i>Location</i>		
Lived in congregate setting (e.g., dorm, residential care facility, corrections, etc.)				<i>Location</i>		
Homeless				<i>Specify location(s) and/or shelter(s)</i>		
Sexual activity				<table border="0" style="width: 100%;"> <tr> <td style="width: 70%;"><i>Sexual partner(s)</i> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Refused</td> <td style="width: 30%;"><i>Engaged in oral-anal sex</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused</td> </tr> </table>	<i>Sexual partner(s)</i> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Refused	<i>Engaged in oral-anal sex</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
<i>Sexual partner(s)</i> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Refused	<i>Engaged in oral-anal sex</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused					

EVENTS OR ACTIVITIES	Yes	No	Unk	If Yes, Specify as Noted
-----------------------------	-----	----	-----	---------------------------------

Exposure to sewage or human excreta				<i>Location</i>
Attend any group activities or events (e.g., parties, shared meals, etc.)				<i>Describe</i>
Other activities or exposures of interest				<i>Describe</i>

WATER EXPOSURES	Yes	No	Unk	If Yes, Specify as Noted
------------------------	-----	----	-----	---------------------------------

Natural recreational water (rivers, lakes, oceans, etc.)				<i>Location</i>
Artificial recreational water (swimming pools, water parks, fountains, etc.)				<i>Location</i>
Drank untreated water				<i>Source(s)</i>

Source(s) of drinking water (check all that apply)
 Public Individual well Shared well Bottled Other: _____ Unk

FOOD HISTORY – OUTSIDE HOME

Did patient consume food or drink prepared outside the home? *If Yes, specify name of place (e.g., restaurant, concession stand, friend's house, etc.), location, date, and items consumed on the next page.*
 Yes No Unk

First three letters of patient's last name:

--	--	--

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	

PATIENT CLEARANCE INFORMATION

Did this patient require clearance to return to daycare, school, or work?
 Yes No Unk If Yes, please provide details below.

PATIENT CLEARANCE INFORMATION – DETAILS

Employer/Situation (place of employment, daycare name, etc.)			Telephone Number	
Street Address		City	State	Zip Code
Was clearance completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of First Clearance Specimen (mm/dd/yyyy)		Date of Final Clearance Specimen (mm/dd/yyyy)	
	If No, specify reason			
Clearance Issues (including use of antibiotics to facilitate clearance, etc.) / Comments				

HOUSEHOLD CONTACTS

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

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 & Time	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 & Time	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 & Time	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 & Time	Comment

First three letters of patient's last name:

--	--	--

ILL CONTACTS

Any contacts with similar illness (including household contacts)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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
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
Name 3	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

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	

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number
--	----------------------------

DISEASE CASE CLASSIFICATION

Case Classification (see case definition on page 7) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable

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 <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information
--

CASE DEFINITION**SHIGELLOSIS (2017)****CLINICAL CRITERIA**

An illness of variable severity commonly manifested by diarrhea, fever, nausea, cramps, and tenesmus. Asymptomatic infections may occur.

LABORATORY CRITERIA**Confirmatory**

Isolation of *Shigella* spp. from a clinical specimen.

Supportive

Detection of *Shigella* spp. or *Shigella*/EIEC in a clinical specimen using a CIDT.

EPIDEMIOLOGIC LINKAGE

A clinically compatible case that is epidemiologically linked to a case that meets the supportive or confirmatory laboratory criteria for diagnosis.

CASE CLASSIFICATION**Confirmed**

A case that meets the confirmed laboratory criteria for diagnosis.

Probable

- A case that meets the supportive laboratory criteria for diagnosis, OR
- A clinically compatible case that is epidemiologically linked to a case that meets the supportive or confirmatory laboratory criteria for diagnosis.

Criteria to distinguish a new case of this disease or condition from reports or notifications which should not be enumerated as a new case for surveillance:

- A case should not be counted as a new case if laboratory results were reported within 90 days of a previously reported infection in the same individual.
- When two or more different serotypes are identified in one or more specimens from the same individual, each should be reported as a separate case.

COMMENT

The use of CIDTs as stand-alone tests for the direct detection of *Shigella*/EIEC in stool is increasing. EIEC is genetically very similar to *Shigella* and will be detected in CIDTs that detect *Shigella*. Specific performance characteristics such as sensitivity, specificity, and positive predictive value of these assays likely depend on the manufacturer and are currently unknown. It is therefore useful to collect information on the type(s) of testing performed for reported shigellosis cases. When a specimen is positive using a CIDT, it is also helpful to collect information on all culture results for the specimen, even if those results are negative.

Culture confirmation of CIDT-positive specimens is ideal, although it might not be practical in all instances. State and local public health agencies should make efforts to encourage reflexive culturing by clinical laboratories that adopt culture-independent methods, should facilitate submission of isolates/clinical material to state public health laboratories, and should be prepared to perform reflexive culture when not performed at the clinical laboratory. Isolates are currently necessary for molecular typing (PFGE and whole genome sequencing) that are essential for outbreak detection and for antimicrobial susceptibility testing, which is increasingly important because of substantial multidrug resistance among *Shigella*.

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

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/mm³, other diagnoses should be considered.

(continued on page 8)

CASE DEFINITION (continued)**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.

RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any 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 any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • Adult film actor/actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker 	<ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other/unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent/guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Volunteer • Other • Refused • Unknown