Shiga-toxigenic *E. coli*
(*Escherichia coli* O157 and others)

ORPHEUS ID

☐ confirmed
☐ presumptive
☐ not suspect
☐ no case

Name ______________________________ County ____________
LAST, first, initials (a.k.a.)

Address ______________________________
Street City

Phone number ______________ / ______________
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

E-mail ______________________________

Special housing
☐ Nursing home/ Asst Living
☐ Homeless
☐ Prison/jail
☐ Foster home
☐ Hospital
☐ Nursing home
☐ Other institution
☐ Drug treatment/ shelter
☐ Women's shelter
☐ YES house
☐ Homeless shelter
☐ Job Corps
☐ Treatment center
☐ Chemawa Indian School
☐ Pacific Univ.
☐ No address on file

ALTERNATE CONTACT

Name ______________________ Phone(s) ______________
LAST, first, initials home (H), work (W), cell (C), mes-

DEMOGRAPHICS

DOB ___/___/___ (m d y) if DOB unknown, AGE _____ Sex ☐ Female ☐ Male Preg ☐ Y ☐ N ☐ unk

Language ______________ Country of birth ______________ ☐ refugee

Worksites/school/day care center ______________ Occupation/grade ______________

Amer Indian/ Alaska Native
☐ American Indian
☐ Alaska Native
☐ Canadian Inuit, Metis First Nation
☐ Indigenous Mexican Central American South American

HISPANIC or Latino/a
☐ Hispanic or Latino/a Central American
☐ Hispanic or Latino/a Mexican
☐ Hispanic or Latino/a

ASIAN
☐ Asian Indian
☐ Chinese
☐ Filipino/a
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ South Asian
☐ Vietnamese
☐ Other Asian

Native Hawaiian/ Pacific Islander
☐ Guamanian or Chamorro
☐ Micronesian
☐ Native Hawaiian
☐ Samoan
☐ Tongan
☐ Other Pacific Islander

Black or African American
☐ African American
☐ African (Black)
☐ Caribbean (Black)
☐ Other Black

Middle Eastern Northern African
☐ Northern African
☐ Middle Eastern

White
☐ Eastern European
☐ Slavic
☐ Western European
☐ Other White

Other Categories
☐ Other (please list) ______________
☐ Don't know/Unknown
☐ Don't want to answer/ Decline

PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
____
____
____

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
____
____
____

☐ Ok to contact patient (only list once)

Local epi_name ______________________________

Date report received by LHD ___/___/___ LHD completion date ___/___/___

Basis of diagnosis next page

CASE'S NAME

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic ☐ yes ☐ no ☐ unk

first symptoms ____/____/____
first vomit/diarrhea ____/____/____
Time: _____________ am/pm

diarrhea	☐ yes	☐ no	☐ unk
bloody diarrhea	☐ yes	☐ no	☐ unk
vomiting	☐ yes	☐ no	☐ unk
HUS	☐ yes	☐ no	☐ unk
TTP	☐ yes	☐ no	☐ unk
any antibiotics	☐ yes	☐ no	☐ unk

Deceased: ☐ yes ☐ no date of death ____/____/____

Cause: ____
☐ related to disease ☐ unrelated to disease ☐ unk

Hospitalized: ☐ yes ☐ no ☐ unk
Hospital Name _________________________________

admit date ____/____/____ ☐ ICU
discharge date ____/____/____

Hospital Name _________________________________
admit date ____/____/____ ☐ ICU
discharge date ____/____/____

LABORATORY DATA ☐ None
Laboratory Name ___________________________________
Collection date ___/___/___ Result date ___/___/____
Specimen type:
☐ stool ☐ blood ☐ urine ☐ other ____________

Test Type	pos	neg	unk
Culture	☐	☐	☐
O157 Antigen	☐	☐	☐
Shigatoxin EIA	☐	☐	☐
if pos, STX-1 ☐ STX-2 ☐			
Shigatoxin PCR	☐	☐	☐
if pos, STX-1 ☐ STX-2 ☐			
Sent to OSPHL	☐	☐	☐

____

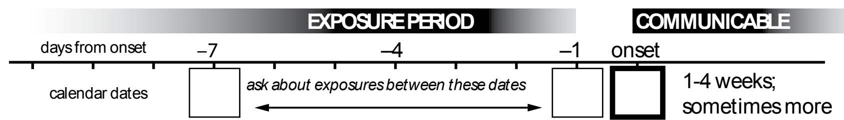
Treatment
Was patient treated with antibiotics or anti-motility drugs for this illness? ☐ yes (specify) ☐ no ☐ unk

Drug name	size/dose/frequency	start date	end date
_______________	_______________	____/____/____	____/____/____
_______________	_______________	____/____/____	____/____/____

CASE'S NAME

INFECTION TIMELINE

Enter onset date of cough in heavy box. Count forwards and backwards to figure probable exposure and communicable periods.



Interviewed ☐ yes ☐ no

First interview attempt: ___/___/___ Interview date(s) ___________________ Interviewed by ___________________

Who ☐ patient ☐ provider ☐ parent ☐ other (specify) __________________

Reason not interviewed (choose one)
☐ not indicated ☐ unable to reach ☐ out of jursdiction ☐ deceased
☐ refused ☐ physician interview ☐ medical record review

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Risks Provide ancillary details (names, locations, details) about possible sources and risk factors. Ask about any leftovers including packaging or containers in the trash, collect some for testing. Contact ACDP for details.

yes	no	ref	unk	**HIGH RISK FOODS**
☐	☐	☐	☐	where did you shop for groceries ___________________________
☐	☐	☐	☐	ground beef handling or cooked in home *if yes*, any leftovers including wrappers
☐	☐	☐	☐	any ground beef
☐	☐	☐	☐	raw/rare meat
☐	☐	☐	☐	raw (unpasteurized) milk
☐	☐	☐	☐	queso fresco/raw milk cheese
☐	☐	☐	☐	venison, other game, hunting
☐	☐	☐	☐	live stock or farm exposure *if yes*, provide details in Notes
☐	☐	☐	☐	dried meat (salami, jerky, etc.)
☐	☐	☐	☐	fresh spinach
☐	☐	☐	☐	fresh lettuce or leafy greens
☐	☐	☐	☐	sprouts (alfalfa, clover, bean)
☐	☐	☐	☐	unpasteurized juice or cider
☐	☐	☐	☐	food at restaurants, fast food, vendors
☐	☐	☐	☐	food at other gatherings (potlucks and events)
☐	☐	☐	☐	work exposure to human or animal excreta
☐	☐	☐	☐	contact with diapered children or adults
☐	☐	☐	☐	recreational water exposure (pools, water parks, backyard splash pools)
☐	☐	☐	☐	drink untreated surface water
☐	☐	☐	☐	recreational wild water exposure (lakes, rivers, streams, natural springs, the ocean)
☐	☐	☐	☐	recreational treated water exposure (swimming pools, hot tubs/spas, water parks, chlorinated fountains)
☐	☐	☐	☐	petting zoos, county fairs, 4H

Y	*N*	**TRAVEL**
☐	☐	outside the US to ______________________
☐	☐	outside Oregon to ______________________
☐	☐	within Oregon to ______________________

Provide details about all travel, see Orpheus
departure ___/___/___ return ___/___/___

Associated with a known outbreak? ☐ yes ☐ no ☐ unk

Close contact of another case ☐ yes ☐ no ☐ unk

Specify nature of contact

☐ co-worker ☐ daycare ☐ friend
☐ household ☐ sexual

Has the above case been reported? ☐ yes ☐ no ☐ unk

If yes to any question, specfiy names, dates, places.

Outbreak ID ___________________________________

FOLLOW-UP

Provide details as appropriate.

yes	no	ref	unk	
☐	☐	☐	☐	does the case know anyone with a similar illneses
☐	☐	☐	☐	is the case in diapers
☐	☐	☐	☐	does case work or attend daycare
☐	☐	☐	☐	are other children/staff ill
☐	☐	☐	☐	daycare/work restriction for case

yes	no	ref	unk	
☐	☐	☐	☐	follow up of household members
☐	☐	☐	☐	water supply testing
☐	☐	☐	☐	case educated about disease tranmission

CASE'S NAME

CONTACT MANAGEMENT

Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Last exposure date	Onset date	Interview date	Sick
______________	_____	☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual ☐ coworker	_________________	☐ Y ☐ N	___/___/___	___/___/___	___/___/___	☐ Y ☐ N
______________	_____	☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual ☐ coworker	_________________	☐ Y ☐ N	___/___/___	___/___/___	___/___/___	☐ Y ☐ N
______________	_____	☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual ☐ coworker	_________________	☐ Y ☐ N	___/___/___	___/___/___	___/___/___	☐ Y ☐ N

ADMINISTRATION

FEBRUARY 2019

Remember to copy patient's name to the top of this page.

Case report sent to OHA on ____/____/____

Completed by __________________________ Date ___________ Phone _________________ Investigation sent to OHA on