Case Investigation

Indiana State Department of Health
State Form 49689 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ☒ ☑ Mark mistakes like this:
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number**

Number & Street Address

City **State** **ZIP Code**

County **Date of Birth** **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care**

Name of: ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code**

Section 2. Clinical Information

Symptoms:
- ○ Fever ___ . _ *(degrees)*
- ○ Diarrhea
- ○ Blood in Stool
- ○ Abdominal Cramps
- ○ Nausea
- ○ Vomiting
- ○ Gas
- ○ Other, specify:

Date of Onset

Duration of Symptoms in Days

Date First Positive Specimen Collected

Source of Positive Specimen:
- ○ Stool
- ○ Blood
- ○ Urine
- ○ Other, specify:

Culture Results:
○ E. coli 0157:H7 ○ E. coli 0157 ○ Sorbitol-negative E. coli ○ No Positive Culture

Was E. coli strain resistant to any antibiotics?
○ Yes ○ No ○ Unknown

If yes, antibiotic:

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code** -

- -
Physician/Hospital Phone

Was the patient taking antibiotics prior to illness onset? ○ Yes ○ No ○ Unknown

If Yes, antibiotic

/ / / /
Date started **Date ended**

Was the patient treated with antibiotics after onset? ○ Yes ○ No ○ Unknown

If Yes, antibiotic

/ / / /
Date started **Date ended**

Was the patient hospitalized? ○ Yes ○ No

If Yes, admission date: / /

Discharge date: / /

Hospital:

Did the patient develop Hemolytic Uremic Syndrome (HUS)? ○ Yes ○ No ○ Unknown

Did the patient die? ○ Yes ○ No

Section 3. Epidemiologic Information

List all commercial food establishments serving ready-to-eat food that the patient patronized during the 5 days prior to illness onset.

1.
Establishment Name

Address

Foods Eaten (list) / /
Date

2.
Establishment Name

Address

Foods Eaten (list) / /
Date

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Section 3. Epidemiologic Information (continued)

3. Establishment Name

Address

Foods Eaten (list) Date / /

4. Establishment Name

Address

Foods Eaten (list) Date / /

List all group gatherings where food was served that the patient attended during the 5 days prior to illness onset.

1. Type of Gathering

Responsible Person

Phone Number - - No. of Persons Date / /

2. Type of Gathering

Responsible Person

Phone Number - - No. of Persons Date / /

3. Type of Gathering

Responsible Person

Phone Number - - No. of Persons Date / /

List all stores where the patient bought groceries that were consumed during the 5 days prior to illness onset.

Store Name:	Street Address:	Date:
		/ /
		/ /
		/ /

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Section 3. Epidemiologic Information (continued)

Indicate whether the patient consumed the following foods or beverages during the 5 days prior to illness onset.

Food Item:	Date Consumed:	Brand Name:	Name of Place Purchased:
○ Ground beef	/ /		
○ Sausage	/ /		
○ Deer meat	/ /		
○ Packaged cold cuts	/ /		
○ Unpast. milk/dairy	/ /		
○ Powdered (dry) milk	/ /		
○ Infant formula	/ /		
○ Apple cider	/ /		
○ Raw vegetables	/ /		
○ Salads	/ /		
○ Lettuce	/ /		
○ Fresh herbs	/ /		
○ Sprouts	/ /		
○ Cole slaw/Cabbage	/ /		
○ Unpasteurized juice	/ /		
○ Raw fruit/melons	/ /		

Section 4. Risk Factors

During the 5 days prior to illness onset, did the patient:

Consume any raw or rare meat, or any unpasteurized milk or dairy products?

○ Yes ○ No ○ Unknown

If Yes, date: / /

Which item(s)?

Have contact with cattle or other livestock?

○ Yes ○ No ○ Unknown

If Yes, date: / /

Type of animal:

Location:

Visit a farm, petting zoo, or animal exhibit?

○ Yes ○ No ○ Unknown

If Yes, date: / /

Type of animal:

Location:

Have contact with deer?

○ Yes ○ No ○ Unknown

If Yes, date: / /

Has the patient had contact with anyone else who has recently had an illness characterized by diarrhea, fever, or abdominal pain?

○ Yes ○ No ○ Unknown

If Yes, name:

Phone number: - -

Onset date: / /

Relationship:

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Section 4. Risk Factors (continued)

Travel outside of Indiana? ○ Yes ○ No ○ Unknown

If Yes, where

__ / __ / __ __ / __ / __

Date of departure **Date of return**

Live, work, or visit a nursing home or long-term care residential facility? ○ Yes ○ No ○ Unknown

If Yes, where

__ / __ / __

Date

Work at or attend a baby-sitting group, day-care center, or preschool? ○ Yes ○ No ○ Unknown

If Yes, where

__ / __ / __

Date

Go swimming? ○ Yes ○ No ○ Unknown

If Yes, where

__ / __ / __

Date

Visit an interactive fountain or water park? ○ Yes ○ No ○ Unknown

If Yes, where

__ / __ / __

If Yes, date

Drink or have contact with untreated water? ○ Yes ○ No ○ Unknown

If Yes, where

__ / __ / __

Date

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

__ - __ - __ __ / __ / __

Phone Number **Date**

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