



BC Verotoxigenic *E. coli* Follow-up Form

Demographic and Contact Information

Patient Surname:		First Name:	PHN:
Birthdate: (e.g. 15/Dec/07)	Sex: F <input type="checkbox"/> M <input type="checkbox"/>	Parent or Guardian: <input type="checkbox"/> Respondent is case	
Address: (street, city, postal code)		Home phone: _____	
E-mail:		Work: _____	
Physician:		Cell: _____	
		Physician Phone: _____	

Case Notification/Assignment

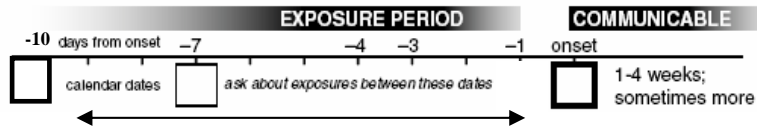
Report Received at HU: (e.g. 15/Dec/07)	
Contact attempts (date and time)	Interview?
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>
Interviewer: <input type="checkbox"/> Not located	

Clinical Information

Species: <input type="checkbox"/> O157:H7 <input type="checkbox"/> _____	Specimen type:	Lab Report Date: (e.g. 15/Dec/07)	Reporting lab:
Onset of Earliest Symptom (e.g. 15/Dec/07): Time: _____ am/pm	Earliest Symptom:	Hospitalized: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Name of Hospital:
Other Symptoms: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea Other: _____ <input type="checkbox"/> Bloody Diarrhea <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Fever	Date of Admission (e.g. 15/Dec/07):	Date of Discharge (e.g. 15/Dec/07):	
	Deceased: <input type="checkbox"/> Y <input type="checkbox"/> N	HUS: <input type="checkbox"/> Y <input type="checkbox"/> N	

Exposure Period

Enter onset date in heavy box. Count back to figure the probable exposure period.



Travel

Infection acquired during travel: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes: <input type="checkbox"/> Within BC <input type="checkbox"/> Within Canada <input type="checkbox"/> Outside Canada
Departure (e.g. 15/Dec/07):
Return (e.g. 15/Dec/07):
Destination(s) (e.g. city, mode of travel):
Foods brought back:

Animal Contact

Farm, Petting Zoo, Agricultural Fair, Wildlife: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Pets (incl reptiles) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Pet treats or Raw food diet (circle): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Details (e.g. dates, location, type of animals):

Food Exposures

Vegetarian? <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies/Avoidances/special diet? <input type="checkbox"/> Y <input type="checkbox"/> N Details:
Social Gatherings (e.g. parties, weddings, showers, potlucks, community event): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Name Location Date of Exposure Food(s) Eaten
Restaurants (including: take-out, cafeteria, bakery, deli, kiosk): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Name Location Date of Exposure Food(s) Eaten
Groceries Consumed During the Incubation Period (including grocery stores, specialty/ethnic stores and markets) :
Store Name Location Details (e.g. items purchased, date of visit)

Specific High Risk Foods/Activities

Food Item/Activity	Eaten	Details Please specify type/ brand where possible	Food Item/Activity	Eaten	Details Please specify type/ brand where possible
Meat			'At risk' water supply	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Ground beef	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Produce		
Hamburger patties	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Lettuce	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Other beef (e.g., steak, roast, donair)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Bagged, pre-washed greens	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Salami/sausage	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Spinach	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Cold cuts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Sprouts (e.g. alfalfa, bean, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Handle raw meats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Unpasteurized ciders/juices	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Dairy			Melon	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Cheese	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Prepared salads (e.g., cole slaw, pasta, potato)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Unpasteurized dairy (e.g., cheese, milk)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Activities		
Water			Contact with daycare	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Recreational water (e.g., pool, beach, spray park)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Contact with LTCF	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	

Contacts # people in household:

Name	Date Ill	Nature of contact*	Occupation/Details	Contact phone	^Excluded?

*Household, sexual, close contacts.

^ Please complete Contact Exclusion Form for each contact excluded.

Occupation and Exclusion

Occupation:

Sensitive Setting (check if applicable):

Work/volunteer or attend day care

Work/volunteer in a health care setting

Work/volunteer as a food handler

Other (e.g. pool): _____

Facility name:

Excluded Y N Effective date (e.g. 15/Dec/07):

Details:

Symptom end date (e.g. 15/Dec/07):

Exclusion lifted: (e.g. 15/Dec/07): MHO:

Case Exclusion Worksheet[†]

Antibiotic Use: Y N DK Length of treatment: _____ days

Date of Discontinuation (e.g. 15/Dec/07):

Sample No.	Date (e.g. 15/Dec/07)	Result	Notes
1		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
2		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
3		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
4		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	

[†] Refer to CD Control Guidelines on Exclusion of Enteric Cases and their Contacts from High Risk Settings

Interventions

<input type="checkbox"/> Referred for Inspection	Details	<input type="checkbox"/> Referred to another HA	Details
<input type="checkbox"/> Hygiene Education Provided		<input type="checkbox"/> Health file sent	
<input type="checkbox"/> Other			

Notes

Date	Comment	Initials