Kansas Department of Health and Environment
Epidemiology and Public Health Informatics

Post-Diarrheal Hemolytic Uremic Syndrome (HUS) Report Form

INTERVIEW

EpiTrax # _____ Interviewer Name:_____

Number of Call Attempts:_____ Date of Interview (must enter MM/DD/YYYY): _____

Follow-up Status:
- ☐ Interviewed
- ☐ Refused Interview
- ☐ Lost to Follow-Up*

Respondent was:
- ☐ Self
- ☐ Parent
- ☐ Spouse
- ☐ Other, *Specify:*_____

*At least three attempts at different times of the day should be made before the considered lost to follow-up.

Was the Shiga-toxin producing Escherichia coli form completed? ☐ Yes ☐ No

(If yes, please enter Diarrheal onset date under clinical section below. If no, please fill out the Shiga-toxin form.)

DEMOGRAPHICS

Birth Gender:
- ☐ Male
- ☐ Female

Date of Birth: _____

Age: _____

Hispanic/Latino Origin:
- ☐Yes
- ☐No
- ☐Unknown

How would you describe your race?
- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other_____
- ☐ Unknown

CLINICAL

Diarrheal Onset date: _____ Date Diagnosed: _____

(Diarrheal Onset date is taken from the STEC form under Clinical Symptoms)

Did you recover?
- ☐ Yes
- ☐ No
- ☐ Unknown

If Yes, Recovery Date: _____

Time Recovered:_____

Were you hospitalized?
- ☐ Yes
- ☐ No
- ☐ Unknown

If Yes, Hospital Name:_____

Admit date: _____ Discharge Date: _____

Was this illness the reason for hospitalization? ☐ Yes ☐ No

Died?

☐Yes ☐No ☐Unknown

If Yes, Date of Death:_____

Was death due to this illness? ☐Yes ☐ No

Are you pregnant?

☐Yes ☐No ☐Unknown

If Yes, Expected Delivery Date: _____

Was diarrhea treated with antibiotics?	☐Yes ☐ No ☐ Unknown
Was antibiotic treatment finished?	☐Yes ☐ No ☐ Unknown
Did you receive antidiarrheal medication for this illness?	☐Yes ☐ No ☐ Unknown
Was antidiarrheal treatment finished?	☐Yes ☐ No ☐ Unknown

Medication Name	Date Started	Date Ended

Additional Clinical Notes:

_____

_____

_____

_____

_____

INVESTIGATION

A. Clinical Symptoms

Hemolytic Uremic Syndrome/Thrombic Thrombocytopenic Purpura (HUS/TTP)

Onset Date: _____

(This date is different from the diarrheal onset date.)

B. Laboratory Information

Lab Test Performed	Status	Lab Result Specifics
Serum hematocrit test	☐ Yes ☐ No ☐ Unknown	Lowest Value (%)_____ Collection Date: _____ Does patient have anemia with acute onset? ☐Yes ☐ No ☐ Unknown
Peripheral blood smear test	☐ Yes ☐ No ☐ Unknown	Does patient have microangiopathic changes? ☐Yes ☐ No ☐ Unknown Collection Date: _____ ☐ Schistocytes ☐ Burr cells ☐ Helmet cells ☐ None ☐ Other (specify) _____
Urine hemoglobin test	☐ Yes ☐ No ☐ Unknown	Does patient have hematuria? ☐Yes ☐ No Collection Date: _____
Urine albumin test	☐ Yes ☐ No ☐ Unknown	Lab result (mg/dl): _____ Collection Date: _____ Does the patient have proteinuria? ☐Yes ☐ No
Serum creatinine test	☐ Yes ☐ No ☐ Unknown	Lab result (mg/dl): _____ Collection Date: _____ Does the patient have elevated creatinine level? ☐Yes ☐ No

Serum BUN test	☐ Yes ☐ No ☐ Unknown	Highest Value (mg/dl):_____ Collection Date: _____
Serum platelets tests	☐ Yes ☐ No ☐ Unknown	Lowest Value (mm^3 or mg.dl):_____ Collection Date: _____

C. Complications

Does this patient have renal failure? ☐ Yes ☐ No ☐ Unknown

Is this patient on dialysis? ☐ Yes ☐ No ☐ Unknown

Additional notes:

_____

_____

_____

_____

_____