

**New Jersey Department of Health
STEC SURVEILLANCE CASE REPORT
RETURN COMPLETED FORM TO NJDOH VIA FAX 609-826-5972**

CDRSS ID#

Section 1: INTERVIEWER & PATIENT INFORMATION:

1. State Lab Isolate ID#: _____ 2. State of residence: ___ __

3. County: _____ 4. Zip code: _____

5. Interviewer Information
 Name: _____ Contact Phone Number: (____) _____ - _____
 Agency or Organization: _____ Date of Interview: ___/___/____ (MM/DD/YYYY)

6. Language interview conducted in English Spanish Other (Specify): _____

7. Respondent was: Self Parent Spouse Other (Specify): _____
 Not interviewed - *If not interviewed, why not?* _____

8. Patient outcome at time of interview: Survived Died Unknown
If died, was this infection considered an underlying, contributing, or immediate cause of death? Yes No Unknown

Section 2: DEMOGRAPHIC DATA:

1. Date of birth: ___/___/____ (MM/DD/YYYY) 2. Age: _____ 3. Sex: Male Female

4. Hispanic or Latino origin? Yes No Unknown

5. How would you describe your (your child's) race?
 White Black / African American American Indian / Alaska Native Unknown
 Asian Native Hawaiian / Other Pacific Islander Other (specify): _____

Section 3: CLINICAL INFORMATION: Now I have a few questions about your (your child's) illness.

1. What date did you (your child) first feel sick? ___/___/____ MM/DD/YYYY

2. How many days in total were you (your child) sick? _____ days Unknown Still sick



3. Prior to onset of symptoms, did you (your child) have any long-lasting or chronic illness or condition {an illness that has lasted longer than 1 month}?
 Yes No Unknown Refused
if yes, please specify _____

| YES | Maybe | NO | Don't Know | Did you (your child) have any: |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Diarrhea (defined as at least 3 loose stools in 24 hours)? a. What date did it start? ___/___/____ (MM/DD/YYYY) <input type="checkbox"/> Unknown b. What date did it stop? ___/___/____ (MM/DD/YYYY) <input type="checkbox"/> Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Blood in stool? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Vomiting? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Nausea? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Abdominal cramps? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Fever (or felt feverish)? 10a. Temperature _____ degrees |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Other? 11 a. Specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. Were you treated with antibiotics for this illness? a. Specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. Were you (your child) hospitalized overnight? (<i>must enter MM/DD/YYYY</i>) a. Hospital Name: _____ b. Admit Date: ___/___/____ c. Discharge Date: ___/___/____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. Did you (your child) receive a diagnosis of Hemolytic Uremic Syndrome (HUS) or kidney failure? <input type="checkbox"/> HUS <input type="checkbox"/> Kidney Failure |

Section 4: TRAVEL AND EVENTS: Next I have a couple of questions about any travel you might have done, either as part of your work or for pleasure in the **7 days** before onset of illness.

| YES | Maybe | NO | Don't Know | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Did you (your child) spend all, or some, of the 7 days before you were ill outside your home state? |
| | | | | a. Reason for travel: _____ |
| | | | | b. List all US states where you might have purchased or eaten foods (Including airports, bus or train stations) States, Cities: _____ Dates of travel: _____ List hotels/resorts stayed in during travel: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Did you (your child) spend all, or some, of the 7 days before you were ill outside the US? |
| | | | | a. Reason for travel: _____ |
| | | | | b. List all countries outside the US where you might have purchased or eaten foods Countries: _____ Dates of travel: _____ List hotels/resorts stayed in during travel: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. In the 7 days before illness onset, did you attend an event where food was served, such as a catered event, conference, wedding, food festival, fair, church, or community meal? |
| | | | | a. Event name: _____ b. Location: _____ c. Items consumed: _____ |
| | | | | a. Event name: _____ b. Location: _____ c. Items consumed: _____ |

 **NOTE TO INTERVIEWER**

| YES | Maybe | NO | Don't Know | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <i>Please refer to Section 4 'TRAVEL AND EVENTS' question (2b.) above. Did the case spend the <u>entire</u> 7 days before illness onset outside the US? If the answer was:</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | NO , please continue with the interview on the next page  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | YES , thank the interviewee for his/her time and end the interview  |

ADDITIONAL COMMENTS:

Section 5: FOOD ALLERGIES & SPECIAL DIETS: Now I have a few questions about general food preferences, food allergies, and any special diets you (your child) may follow.

1. Do you (your child) avoid eating or never eat any of the following foods, due to restriction or preference?

Dairy products (butter, dairy milk, cheese, etc.) Poultry (chicken, turkey, etc.) Beef

Eggs Pork Seafood (fish, crab, shrimp, etc.)

Other, specify: _____

2. Do you (your child) follow any of the following special or restricted diets?

Kosher Raw foods Paleo (high protein, low carb) Dairy-free Weight loss/low fat

Halal Low carb Vegetarian/Vegan Gluten-free Other, specify _____

Section 6: SOURCES OF FOOD AT HOME: Now I have a few questions about where the food came from that you (your child) ate **at home** in the **7 days** before your illness began. This isn't necessarily only where you shopped during that week, but please tell me the names of each store you would have eaten food from during the 7 days before you were sick.

1. Did you (your child) eat foods from:

Grocery stores or supermarkets Fish or meat specialty shops (butcher shops, etc.)

Warehouse stores (Costco, Sam's Club, etc.) Live animal market, custom slaughter facility

Small markets/Mini markets (convenience stores, gas stations, etc.) Health food stores or co-ops

Ethnic Specialty markets (Mexican, Asian, Indian) Farmers' markets, roadside stands, open-air markets, directly from farm

Home delivery grocery services (CSA, grocery delivery, Amazon Fresh, Peapod, etc.) Others?

Meal delivery services (Blue Apron, Meals on Wheels, NutriSystem, etc.)

Please list store names, address/location, and shopper card # (if applicable) mentioned by the interview below:

| Store/Supermarket Name | Address/Location | Shopper card # |
|------------------------|------------------|----------------|
| | | |
| | | |
| | | |
| | | |

2. May we have permission to retrieve purchases based on your member card information? This will be kept confidential. Yes No

Section 7: SOURCES OF FOOD OUTSIDE THE HOME: Now I have a few questions about where the food came from that you (your child) ate **outside your home** such as restaurants or fast food chains. For each, please tell me the names of each place you would have eaten food from during the **7 days** before you were sick.

1. Did you (your child) eat foods from:

Fast casual (Chipotle, Panera, etc.) All-you-can-eat buffet

Jamaican, Cuban, or Caribbean Any take-out from a restaurant

Mexican, Salvadorian, other Hispanic/Latino-style Salad bar at a grocery store or restaurant

Chinese, Japanese, Vietnamese, other Asian-style Sandwich shop, deli

Middle Eastern, Greek/Mediterranean, Arabic, Lebanese, African Breakfast, brunch, diner, or café

Healthy restaurant (vegetarian, vegan, salad-based) School, hospital, senior center, or other institutional setting

Fast Food (McDonalds, Burger King, Wendy's, etc.) An event where food was served (catered event, festival, church or community meal)

Ready-to-eat prepared food from grocery or deli Any others?

Food trucks, food stalls/stands

Please list restaurant/store names and address/location mentioned by the interviewee below:

| Restaurant Name | Address/Location | Meal Date(s) | Food Ordered/Eaten |
|-----------------|------------------|--------------|--------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Section 8: FOOD HISTORY: Now I'd like to ask you about specific food items.

DAIRY ITEMS / JUICES

| YES | Maybe | NO | Don't Know | During the 7 days before you (your child) got sick, did you eat the following items: |
|---|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Milk from a cow or other animal source? |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | a. Type (cow, goat, etc.) _____ Brand/Location Purchased _____ b. Raw or unpasteurized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Cheese made from raw milk? |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | a. Type (cow, goat, etc.) _____ Brand/Location purchased _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Artisanal or gourmet cheese? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Farmer's cheese? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Queso fresco, or queso blanco? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Other cheese, specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Raw or unpasteurized Juice or cider? <input type="checkbox"/> Apple <input type="checkbox"/> Orange <input type="checkbox"/> Other: _____ |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | a. Brand/Location Purchased _____ |

MEATS

| YES | Maybe | NO | Don't Know | During the 7 days before you (your child) got sick, did you (your child): |
|---|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Handle ground beef, even if you (your child) did not eat it? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Eat any ground beef, such as hamburger patties, casseroles, tacos, soups, or pasta sauces? |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | a. If eaten <u>at home</u> , what was the: Dish (please describe): _____ Place purchased from (names, locations): _____ What % fat or lean? _____ Purchased as patties? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | b. If eaten <u>outside the home</u> , where? List name(s) & location(s): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Eat any steaks, roasts, or other whole cuts of beef? |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | a. If eaten <u>at home</u> , what was the: Type, variety, brand: _____ Place purchased from (names, locations): _____ |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | b. If eaten <u>outside the home</u> , where? List name(s) & location(s) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Any other beef? |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | a. Specify: _____ |

5. During the **7 Days** before you (your child) got sick, did you (your child) eat any of the following items:

Bison Elk Venison Boar Other wild game, Specify: _____
 Salami Sausage Pepperoni Beef or other jerky Other dried or fermented meats, Specify: _____

FRESH / UNCOOKED SALADS

| YES | Maybe | NO | Don't Know | During the 7 days before you (your child) got sick, did you (your child) eat the following items: |
|---|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Iceberg lettuce? |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | a. Prepackaged or whole head/loose? <input type="checkbox"/> Prepackaged <input type="checkbox"/> Whole head/Loose <input type="checkbox"/> Unknown Was it: <input type="checkbox"/> Whole leaf <input type="checkbox"/> Shredded <input type="checkbox"/> Topping/garnish <input type="checkbox"/> Other, specify: _____ |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | b. If eaten <u>at home</u> , what was the: Type, variety, brand: _____ Place purchased from (names, locations): _____ |
| <div style="border-top: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> | | | | c. If eaten <u>outside the home</u> , where? List name(s) and locations(s): _____ |

| YES | Maybe | NO | Don't Know | During the 7 days before you (your child) got sick, did you (your child) eat the following items: |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Romaine lettuce? |
| | | | | a. Prepackaged or whole head/loose? <input type="checkbox"/> Prepackaged <input type="checkbox"/> Whole head/Loose <input type="checkbox"/> Unknown Was it: <input type="checkbox"/> Whole leaf <input type="checkbox"/> Shredded <input type="checkbox"/> Topping/garnish <input type="checkbox"/> Other, specify: _____ |
| | | | | b. If eaten <u>at home</u> , what was the: Type, variety, brand: _____ Place purchased from (names, locations): _____ |
| | | | | c. If eaten <u>outside the home</u> , where? List name(s) and locations(s): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Fresh Spinach? |
| | | | | a. Prepackaged or loose/bundled? <input type="checkbox"/> Prepackaged <input type="checkbox"/> Loose/Bundled <input type="checkbox"/> Unknown |
| | | | | b. If eaten <u>at home</u> , what was the: Type, variety, brand: _____ Place purchased from (names, locations): _____ |
| | | | | c. If eaten <u>outside the home</u> , where? List name(s) and locations(s): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Fresh, uncooked leafy greens in a salad, on a sandwich, or burger? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Kale? |
| | | | | Type, variety, brand: _____ <input type="checkbox"/> Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Cabbage? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Arugula? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Spring mix/mesclun mix or other lettuce blend? |
| | | | | Type, variety, brand: _____ <input type="checkbox"/> Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other leafy greens, like Swiss chard, mustard greens, dandelion, watercress? |
| | | | | Type, variety, brand: _____ <input type="checkbox"/> Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Other pre-packaged leafy greens or salad kits? |
| | | | | Type, variety, brand: _____ <input type="checkbox"/> Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Pre-made, single-serving salads (these are ready-to-eat, single-serve salads with toppings, meats, dressing)? |
| | | | | Type, variety, brand: _____ <input type="checkbox"/> Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. Alfalfa sprouts, sometimes served on sandwiches or salads? |
| | | | | a. If eaten <u>at home</u> , what was the: Type, variety, brand: _____ Place purchased from (names, locations): _____ |
| | | | | b. If eaten <u>outside the home</u> , where? List name(s) and locations(s): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. Bean sprouts, such as mung bean or soy bean (usually served in stir fries or Asian salads or soups)? |
| | | | | a. If eaten <u>at home</u> , what was the: Type, variety, brand: _____ Place purchased from (names, locations): _____ |
| | | | | b. If eaten <u>outside the home</u> , where? List name(s) and locations(s): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. Other sprouts (clover, daikon radish, microgreens, etc.)? |
| | | | | a. If eaten at home, what was the: Type, variety, brand: _____ Place purchased from (names, locations): _____ |
| | | | | b. If eaten outside the home, where? List name(s) and locations(s): _____ |

Section 9: OTHER EXPOSURES: Now I'd like to ask you about any contact with water and contact with animals.

What is your (your child's) main source of drinking water?

- Individual well Shared well Public water system Bottled water Don't Know Other, specify: _____

| YES | Maybe | NO | Don't Know | In the 7 days before you (your child) became sick, |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Did you (your child) swim or wade in any treated or untreated recreational water facilities? Name/Location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Did you (your child) visit a petting zoo or have direct contact with livestock animals? a. <input type="checkbox"/> Petting zoo <input type="checkbox"/> 4H event <input type="checkbox"/> Fair <input type="checkbox"/> Farm <input type="checkbox"/> Other, specify: _____ b. What type of animals? <input type="checkbox"/> Cattle <input type="checkbox"/> Sheep <input type="checkbox"/> Goats <input type="checkbox"/> Pigs <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Did you (your child) have direct contact with pets? Details: _____ |

Section 10: HIGH RISK OCCUPATIONS OR ACTIVITIES

| YES | Maybe | NO | Don't Know | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you handle or prepare food as part of your duties at work or as a volunteer? Name/Location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you provide health care? Name/Location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you attend or work in a daycare setting? Name/Location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you live in, work at, visit or volunteer in any long-term care/residential facilities? Name/Location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Did you (your child) have close contact with anyone with diarrhea or vomiting in the 7 days prior to illness onset? a. When did this person first become ill? <input type="checkbox"/> <24 hrs. before you <input type="checkbox"/> ≥ 24 hrs. before you <input type="checkbox"/> Unknown |

This is the end of the questionnaire.

Thank you very much for your time. These interviews are extremely valuable in helping us understand how and why people are getting sick. Depending on what we find out when we put these interviews together, we may need to talk to you again about a few details.

Would you like to provide any additional thoughts or perspective about anything we've discussed or about this outbreak investigation?

FOR NJDOH USE ONLY

STEC TYPE: 0157:H7 NON 0157: type _____ Sent to CDC for typing PCR ONLY

Associated with a PulseNet cluster? YES NO If yes, the cluster code is _____ PFGE DATE: _____