



Send completed forms to DPHHS CDEpi Program  
Fax: 800-616-7460

# Enterohemorrhagic *E. coli* (*E. coli*, shiga toxin-producing)

County \_\_\_\_\_

LHJ Use ID \_\_\_\_\_  
 Reported to DPHHS Date \_\_\_/\_\_\_/\_\_\_  
 LHJ Classification  Confirmed  
 Probable  
 Suspect  
 By:  Lab  Clinical  Epi Link

Outbreak-related

LHJ Cluster# \_\_\_\_\_

LHJ Cluster Name: \_\_\_\_\_

DPHHS Outbreak # \_\_\_\_\_

## REPORT SOURCE

LHJ notification date \_\_\_/\_\_\_/\_\_\_ Investigation start date \_\_\_/\_\_\_/\_\_\_  
 Reporter (check all that apply)  Lab  Hospital  HCP  
 Public health agency  Other  
 OK to talk to case?  Yes  No  DK Date of interview \_\_\_/\_\_\_/\_\_\_

Reporter name \_\_\_\_\_  
 Reporter phone \_\_\_\_\_  
 Primary HCP name \_\_\_\_\_  
 Primary HCP phone \_\_\_\_\_

## PATIENT INFORMATION

Name (last, first) \_\_\_\_\_  
 Address \_\_\_\_\_  Homeless  
 City/State/Zip \_\_\_\_\_  
 Phone(s)/Email \_\_\_\_\_  
 Alt. contact  Parent/guardian  Spouse  Other Name: \_\_\_\_\_  
 Zip code (school or occupation): \_\_\_\_\_ Phone: \_\_\_\_\_  
 Occupation/grade \_\_\_\_\_  
 Employer/worksite \_\_\_\_\_ School/child care name \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_  
 Gender  F  M  Other  Unk  
 Ethnicity  Hispanic or Latino  
 Not Hispanic or Latino  Unk  
 Race (check all that apply)  
 Amer Ind/AK Native  Asian  
 Native HI/other PI  Black/Afr Amer  
 White  Other  Unk

## CLINICAL INFORMATION

Onset date: \_\_\_/\_\_\_/\_\_\_  Derived Diagnosis date: \_\_\_/\_\_\_/\_\_\_ Illness duration: \_\_\_\_\_ days

### Signs and Symptoms

Y N DK NA  
    Diarrhea Maximum # of stools in 24 hours: \_\_\_\_\_  
    Bloody diarrhea  
    Abdominal cramps or pain  
    Nausea  
    Vomiting  
    Fever Highest measured temp (°F): \_\_\_\_\_  
 Oral  Rectal  Other: \_\_\_\_\_  Unk

### Hospitalization

Y N DK NA  
    Hospitalized at least overnight for this illness  
 Hospital name \_\_\_\_\_  
 Admit date \_\_\_/\_\_\_/\_\_\_ Discharge date \_\_\_/\_\_\_/\_\_\_  
 Y N DK NA  
    Died from illness Death date \_\_\_/\_\_\_/\_\_\_  
    Autopsy Place of death \_\_\_\_\_

### Predisposing Conditions

Y N DK NA  
    Antibiotic taken for this diarrheal illness  
    Underlying illness, specify: \_\_\_\_\_  
    Pica (eating dirt)

### Laboratory

Collection date \_\_\_/\_\_\_/\_\_\_  
 Source \_\_\_\_\_

P = Positive O = Other  
 N = Negative NT = Not Tested  
 I = Indeterminate

### P N I O NT

*E. coli* O157:H7 culture  
     Non-O157:H7 Shiga toxin+ *E. coli* culture  
 Type if non-O157:H7 \_\_\_\_\_  
     *E. coli* O157 (no H type) Shiga toxin+ culture  
     *E. coli* O157 (no H type) culture, without Shiga toxin+ [*Probable*]  
     EHEC titer elevated Type: \_\_\_\_\_  
 [*Probable*]  
     Shiga toxin assay, no isolation of *E. coli*  
 [*Suspect*]  
     Shiga-toxin *E. coli* PCR, molecular assay

### Clinical Findings

Y N DK NA  
    Hemolytic uremic syndrome (HUS)  
    Thrombotic thrombocytopenic purpura (TTP)  
    Coagulopathy (platelets < 100,000)  
    Acute anemia with microangiopathic changes  
    Kidney (renal) abnormality or failure  
    Kidney dialysis as result of illness

### Notes

<b>Montana Department of Public Health and Human Services</b>	<b>Case Name:</b>
<b>INFECTION TIMELINE:</b> All questions refer to the 2 – 10 days before onset.	
Days from onset:	Exposure period
Calendar dates:	-10 days      -2 days
	Onset
	Contagious period (weeks)

**EXPOSURES**

<b>EXPOSURE</b> (Refer to dates above)	Case knows anyone with similar symptoms <input type="checkbox"/> household contact <input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> other attendees at common event <input type="checkbox"/> lab confirmed case <input type="checkbox"/> Other, specify _____	Details:
<b>Y N DK NA</b>	<b>Epidemiologic link to a confirmed human case</b>	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Contact with diapered or incontinent child or adult	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Visited, lived or worked in a residential facility	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Travel out of the state, out of the country, or outside of usual routine	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Were you on any kind of special or restricted diet for medical, weight loss, religious or other reasons?	If yes, describe:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Any allergies that prevent you from eating: <input type="checkbox"/> Milk <input type="checkbox"/> Other dairy <input type="checkbox"/> Eggs <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree nuts <input type="checkbox"/> Fish <input type="checkbox"/> Soy <input type="checkbox"/> Wheat <input type="checkbox"/> Shellfish <input type="checkbox"/> Other _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vegetarian or vegan diet	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Known contaminated food product? Specify: _____	

**Sources of food**

Sources of food: (check all that apply)	List Store/Retail Names & Locations:
<input type="checkbox"/> Grocery store or supermarkets <input type="checkbox"/> Warehouse stores (e.g., Costco, Sam's Club) <input type="checkbox"/> Small markets, mini marts & convenience stores <input type="checkbox"/> Deli counters <input type="checkbox"/> Ethnic specialty markets (Mexican, Asian or Indian) <input type="checkbox"/> Health food stores or Co-ops <input type="checkbox"/> Fish or meat specialty shops (butcher's shop, etc.) <input type="checkbox"/> Farmer's markets, roadside stands, open-air markets, or food purchased directly from a farm <input type="checkbox"/> School or other institutional setting <input type="checkbox"/> Food samples in stores <input type="checkbox"/> Other, specify: _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Group meal, (e.g., potluck, reception)

**Foods consumed outside the home (including restaurants, schools, etc.)**

Date/Time of Meal	Restaurant/School/Facility Name & Location	Meal description

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_____	_____
_____	Onset
_____	Contagious period (weeks)
_____	_____

**Meat**

<p><b>Y N DK NA</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Consumed</b> any beef  <input type="checkbox"/> Ground beef   <input type="checkbox"/> Steak   <input type="checkbox"/> Stew   <input type="checkbox"/> Roast</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Consumed</b> any other red meat  <input type="checkbox"/> Lamb   <input type="checkbox"/> Goat   <input type="checkbox"/> Pork   <input type="checkbox"/> Wild Game  <input type="checkbox"/> Other _____          If so, how prepared: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed <b>undercooked</b> red meat (which one(s))?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Handled</b> any raw red meat, even if you did not eat it  <input type="checkbox"/> Beef   <input type="checkbox"/> Lamb   <input type="checkbox"/> Goat   <input type="checkbox"/> Venison   <input type="checkbox"/> Other _____          Meat was: <input type="checkbox"/> Ground   <input type="checkbox"/> Steak   <input type="checkbox"/> Stew   <input type="checkbox"/> Roast</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____          Date bought: _____          If steak, type/cut: _____</p>
<p><b>Y N DK NA</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Consumed</b> any chicken  <input type="checkbox"/> Whole chicken   <input type="checkbox"/> Parts   <input type="checkbox"/> Fried   <input type="checkbox"/> Nuggets</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Consumed</b> any other poultry meat  <input type="checkbox"/> Turkey   <input type="checkbox"/> Duck   <input type="checkbox"/> Wild Fowl  <input type="checkbox"/> Other _____          If so, how prepared: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed <b>undercooked</b> poultry meat (which one(s))?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Handled</b> any raw poultry, even if you did not eat it  <input type="checkbox"/> Chicken   <input type="checkbox"/> Turkey   <input type="checkbox"/> Duck   <input type="checkbox"/> Wild Fowl   <input type="checkbox"/> Other _____</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____          Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Consumed</b> any other meats  <input type="checkbox"/> Deli meats: _____   <input type="checkbox"/> Hot Dogs   <input type="checkbox"/> Pepperoni   <input type="checkbox"/> Salami  <input type="checkbox"/> Bologna   <input type="checkbox"/> Italian-style meats   <input type="checkbox"/> Dried meat strips or jerky</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deli meat products? Specify _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Meat salads? Specify _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frozen meat products? Specify _____</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____          Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Consumed</b> any seafood  <input type="checkbox"/> Tuna   <input type="checkbox"/> Salmon   <input type="checkbox"/> Shrimp   <input type="checkbox"/> Shellfish  <input type="checkbox"/> Other _____</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____          Date bought: _____</p>

**Raw/Unpasteurized Products**

<p><b>Y N DK NA</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Raw milk          • Type: <input type="checkbox"/> Cow   <input type="checkbox"/> Goat   <input type="checkbox"/> Other, specify _____</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____          Date bought: _____          Is there product remaining? <input type="checkbox"/> Y   <input type="checkbox"/> N   <input type="checkbox"/> Unk</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cheese made from raw milk          • Type: <input type="checkbox"/> Queso fresco   <input type="checkbox"/> Queso blanco  <input type="checkbox"/> Other, specify _____</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____ Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Artisanal or gourmet cheese          • Type: _____</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____ Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized juice or cider          • Type: _____</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____ Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other unpasteurized product?          • Type: <input type="checkbox"/> Kefir   <input type="checkbox"/> Ice cream   <input type="checkbox"/> Other, specify _____</p>	<p><i>Purchase information:</i>          Facility and location: _____          Brand: _____ Date bought: _____</p>

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Days from onset:	Exposure period		Onset	Contagious period
	-10 days	-2 days		(weeks)
Calendar dates:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Fruit**

**Y N DK NA** Fresh fruit

- Type:  Berries  Pre-cut fruit  Whole fruit  
 Watermelon  Cantaloupe  Honeydew  
 Tropical (e.g. pineapple, kiwi, mango)  
 Other, specify \_\_\_\_\_
- Specify:

*Purchase information:*  
 Facility and location: \_\_\_\_\_  
 Brand: \_\_\_\_\_  
 Date bought: \_\_\_\_\_

Frozen fruit  
 • Specify:

**Leafy Greens**

**Y N DK NA** Iceberg lettuce

- Any Iceberg lettuce eaten at home?  Y  N  Unk
- In what form(s) was the Iceberg lettuce purchased?  
 Pre-packaged/bagged  Loose/Head  Both
- Any Iceberg lettuce outside the home?  Y  N  Unk
- Form of Iceberg lettuce outside home:  
 On burger/sandwich/wrap  Salad/salad bar  
 Both  Other

*Purchase information:*  
 Facility and location: \_\_\_\_\_  
 Brand: \_\_\_\_\_  
 Date bought: \_\_\_\_\_

*Iceberg outside the home details:*

Romaine lettuce

- Any Romaine lettuce eaten at home?  Y  N  Unk
- In what form(s) was the Romaine lettuce purchased?  
 Pre-packaged/bagged  Loose/Head  Both
- Any Romaine lettuce outside the home?  Y  N  Unk
- Form of Romaine lettuce outside home:  
 On burger/sandwich/wrap  Salad/salad bar  
 Both  Other

*Purchase information:*  
 Facility and location: \_\_\_\_\_  
 Brand: \_\_\_\_\_  
 Date bought: \_\_\_\_\_

*Romaine outside the home details:*

Spinach

- Any spinach eaten at home?  Y  N  Unk
- In what form(s) was the spinach purchased?  
 Pre-packaged/bagged  Loose/Head  Both
- Any spinach eaten outside the home?  Y  N  Unk
- Form of spinach outside home:  
 On burger/sandwich/wrap  Salad/salad bar  
 Both  Other

*Purchase information:*  
 Facility and location: \_\_\_\_\_  
 Brand: \_\_\_\_\_  
 Date bought: \_\_\_\_\_

*Spinach outside the home details:*

Other leafy greens

- Type:  Mesclun  Red leaf  
 Spring mix  Butter  
 Radicchio  Baby salad greens  
 Herb mix  Kale  
 Other, specify \_\_\_\_\_

*Purchase information:*  
 Facility and location: \_\_\_\_\_  
 Brand: \_\_\_\_\_  
 Date bought: \_\_\_\_\_  
 Packaging type:  Pre-packaged  Loose/Head  
 Other, specify \_\_\_\_\_  Unknown

**Nuts**

**Y N DK NA** Any nuts

- Type:  Nuts  Nut Butter  Peanut Butter  
 Peanuts  Hazelnuts  Cashews  
 Pistachios  Pine Nuts  
 Other, specify \_\_\_\_\_

*Purchase information:*  
 Facility and location: \_\_\_\_\_  
 Brand: \_\_\_\_\_  
 Date bought: \_\_\_\_\_

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Calendar dates:			

**Vegetables**

Y	N	DK	NA	Sprouts • Type: <input type="checkbox"/> Alfalfa <input type="checkbox"/> Clover <input type="checkbox"/> Bean <input type="checkbox"/> Broccoli <input type="checkbox"/> Daikon radish <input type="checkbox"/> Other, specify _____	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fresh herbs • Type: <input type="checkbox"/> Basil <input type="checkbox"/> Cilantro <input type="checkbox"/> Parsley <input type="checkbox"/> Sage <input type="checkbox"/> Thyme <input type="checkbox"/> Dill <input type="checkbox"/> Other, specify _____	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fresh vegetables • Type: <input type="checkbox"/> Tomatoes <input type="checkbox"/> Cucumbers <input type="checkbox"/> Celery <input type="checkbox"/> Guacamole <input type="checkbox"/> Salsa <input type="checkbox"/> Peppers <input type="checkbox"/> Other, specify _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other fresh vegetables • Specify: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other frozen vegetables • Specify: _____	<i>Details</i>

**Water**

Y	N	DK	NA	Source of drinking water known • Type: <input type="checkbox"/> Individual well <input type="checkbox"/> Shared well <input type="checkbox"/> Public water system <input type="checkbox"/> Bottled water <input type="checkbox"/> Other: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drank untreated/unchlorinated water (e.g. surface, well)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational water exposure • Type: <input type="checkbox"/> Natural water <input type="checkbox"/> Pools, spas, fountain, water park <input type="checkbox"/> Both <input type="checkbox"/> Other: _____	

**Animal Contact**

Y	N	DK	NA	Any contact with animals? • Type: <input type="checkbox"/> Cow/calf <input type="checkbox"/> Goat <input type="checkbox"/> Sheep <input type="checkbox"/> Deer <input type="checkbox"/> Horse/pony <input type="checkbox"/> Donkey <input type="checkbox"/> Any Reptile <input type="checkbox"/> Snake <input type="checkbox"/> Turtle <input type="checkbox"/> Lizard <input type="checkbox"/> Hedgehog <input type="checkbox"/> Parrot <input type="checkbox"/> Live poultry <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Visit or work at any of the following locations, even if no direct animal contact? <input type="checkbox"/> Live on farm <input type="checkbox"/> Dairy farm <input type="checkbox"/> Petting zoo <input type="checkbox"/> Slaughter house <input type="checkbox"/> Veterinary <input type="checkbox"/> Fair <input type="checkbox"/> 4-H event/ show <input type="checkbox"/> Shelter <input type="checkbox"/> Pet shop <input type="checkbox"/> Hunting <input type="checkbox"/> Research <input type="checkbox"/> Other _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household member works with animals • Specify: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raw pet food / treats	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apply compost/manure	

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Days from onset:	Exposure period		Onset	Contagious period (weeks)
	-10 days	-2 days	<input type="text"/>	<input type="text"/>
Calendar dates:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**EXPOSURE SUMMARY**

<p><b>How was this person likely exposed to the disease:</b>  <input type="checkbox"/> Food <input type="checkbox"/> Drinking Water <input type="checkbox"/> Recreational water <input type="checkbox"/> Person  <input type="checkbox"/> Animal <input type="checkbox"/> Environment <input type="checkbox"/> Unknown</p> <p><b>Where did exposure probably occur?</b>  <input type="checkbox"/> U.S. but not MT (State: _____)  <input type="checkbox"/> In MT (County: _____)  <input type="checkbox"/> Not in U.S. (Country/Region: _____)  <input type="checkbox"/> Unknown</p>	<p><b>Exposure details (e.g., exposure date, specific site, purchase or use-by date, product name/description):</b>          _____          _____</p> <p><input type="checkbox"/> No risk factors or exposures could be identified  <input type="checkbox"/> Patient could not be interviewed</p>
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**PUBLIC HEALTH ISSUES** **PUBLIC HEALTH ACTIONS**

<p><b>Y N DK NA</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed as food worker</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Non-occupational food handling (e.g. potlucks, receptions) during contagious period</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed as health care worker</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed in child care or preschool</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Attends child care or preschool</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Household member or close contact in sensitive occupation or setting (HCW, child care, food)</p>	<p><input type="checkbox"/> Exclude from sensitive occupation (HCW, food worker, child care) or situations (child care) until 2 negative stools</p> <p><input type="checkbox"/> Hygiene education provided Date: ___/___/___</p> <p><input type="checkbox"/> Restaurant inspection</p> <p><input type="checkbox"/> Child care inspection</p> <p><input type="checkbox"/> Testing of home/other water supply</p> <p><input type="checkbox"/> Initiate traceback investigation</p> <p><input type="checkbox"/> Other, specify: _____</p>
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**NOTES**

Investigator _____ Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____	Record complete date ___/___/___