New Jersey Department of Health

HEMOLYTIC UREMIC SYNDROME (POST-DIARRHEAL) REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race	Ethnicity
☐ White ☐ American Indian ☐ Unknown/Other ☐ Black ☐ Asian	☐ Hispanic ☐ Unknown ☐ Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Hospitalized-Date of Admission:**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	☐ Yes ☐ No ☐ Unknown	☐ Possible ☐ Probable ☐ Confirmed

Clinical Manifestations:

1. Anemia: ☐ Yes ☐ No
2. Renal injury: ☐ Yes ☐ No
3. History of acute gastrointestinal illness within the last 3 weeks (ask specifically about E. coli O157:H7 or Shigella dysenteriae infections): ☐ Yes ☐ No

   If Yes, specify: _____

Laboratory Test Results (Attach copy of lab reports)

1. Hemoglobine: _____
2. Microangiopathic changes (schistocytes, burr cells or helmet cells) on peripheral blood smear present:: ☐ Yes ☐ No
3. Creatinine: _____ BUN: _____
4. Hematuria: ☐ Yes ☐ No Proteinuria: ☐ Yes ☐ No
5. Stool bacteriological examination: _____ ☐ Not done

Comments:

Name and Title of Person Submitting Report	Telephone Number

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