

Hemolytic Uremic Syndrome, Post- Diarrheal Investigation Guidelines

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Hemolytic Uremic Syndrome, Post-Diarrheal Investigation Guidelines

CASE DEFINITION (CDC 1996)

A. Clinical Description for Public Health Surveillance:

Hemolytic uremic syndrome (HUS) is characterized by the acute onset of microangiopathic hemolytic anemia, renal injury, and low platelet count. Thrombotic thrombocytopenic purpura (TTP) also is characterized by these features but can include central nervous system (CNS) involvement and fever and may have a more gradual onset. Most cases of HUS (but few cases of TTP) occur after an acute gastrointestinal illness (usually diarrheal).

B. Laboratory Criteria for Case Classification:

- Anemia (acute onset) with microangiopathic changes (i.e., schistocytes, burr cells, or helmet cells) on peripheral blood smear and
- Renal injury (acute onset) evidenced by either hematuria, proteinuria, or elevated creatinine level (i.e., greater than or equal to 1.0 mg/dl in a child aged less than 13 years or greater than or equal to 1.5 mg/dl in a person aged greater than or equal to 13 years, or greater than or equal to 50% increase over baseline) specimen

Note: A low platelet count can usually, but not always, be detected early in the illness, but it may then become normal or even high. If a platelet count obtained within 7 days after onset of the acute gastrointestinal illness is not less than 150,000/mm³, other diagnoses should be considered.

C. Case Classification:

- Confirmed: An acute illness diagnosed as HUS or TTP that meets the laboratory criteria and began within 3 weeks after onset of an episode of acute or bloody diarrhea.
- Probable:
 - An acute illness diagnosed as HUS or TTP that meets the laboratory criteria in a patient who does not have a clear history of acute or bloody diarrhea in preceding 3 weeks or
 - An acute illness diagnosed as HUS or TTP that a) has onset within 3 weeks after onset of an acute or bloody diarrhea and b) meets the laboratory criteria except that microangiopathic changes are not confirmed.

D. Laboratory Testing:

- Collection: Use an enteric kit (bottle with a Cary-Blair medium (0.16% agar))
- Specimen: Feces
- Amount: Marble size (preferred) or two rectal swabs per container.
- Blood counts, urinalysis, and serum creatinine tests are available commercially.
- For additional information and/or questions concerning specimen collection/transport and laboratory kits call (785) 296-1620 or refer to online guidance at http://www.kdheks.gov/labs/lab_ref_guide.htm.

E. Bioterrorism Potential:

None.

F. Outbreak Definition:

Unexpected, unexplained increase in cases clustered by time, place, or person.

INVESTIGATOR RESPONSIBILITIES

A. Investigation Relate Tasks and Activities:

- 1) Confirm diagnosis with appropriate medical provider
 - Before contacting the patient, discuss with the health care provider what the patient has been told about his/her evaluation for disease.
 - Obtain information that supports clinical findings in case definition and information on the date of service or onset date of the symptoms.
 - Obtain information on laboratory tests performed and results.
 - If a stool culture has not been performed, a stool specimen should be sent to the state laboratory for culture to try to identify a causative agent.
 - If patient hospitalized, obtain medical records, including admission notes, progress notes, lab report(s), and discharge summary.
- 2) Conduct case investigation to identify potential source of infection.
- 3) Conduct contact investigation to locate additional cases and/or contacts.
 - Determine if case is involved in a high-risk occupation or if another special situation is involved (e.g. food handler, daycare provider or attendee, direct patient care provider, etc.).
- 4) Initiate control and prevention measures to prevent spread of disease.
 - Provide education that includes basic information about the disease and way to prevent transmission of illness.
 - If needed, work with appropriate regulatory personnel to ensure that work restrictions or exclusions are initiated for high-risk cases and/or contacts (e.g. food handler, daycare provider/attendee, direct patient care provider).
- 5) Report all cases to the KDHE Office of Surveillance and Epidemiology at KDHE using established methods.

B. Notifications:

- No special notifications or additional reporting unless the case is associated with an outbreak. The investigator should then immediately notify the Local Health Officer, the local on-call epidemiologist and KDHE (1-877-427-7317).
- As appropriate, use the notification letter and the disease fact sheet to notify the case, contacts and other individuals or groups.

EPIDEMIOLOGY

Hemolytic uremic syndrome (HUS) occurs as a complication in about 8% of diagnosed *E. coli* 0157:H7 cases, particularly children. It is also a complication in *Shigella dysenteriae* infections.

DISEASE OVERVIEW

A. Agent:

Most often a complication of infection with a shiga toxin-producing *E. coli* (STEC), most commonly *E. coli* 0157:H7, or with *Shigella dysenteriae*.

B. Clinical Description:

Syndrome presenting after an acute gastrointestinal illness characterized by microangiopathic hemolytic anemia, acute renal failure and thrombocytopenia. Early clinical signs of HUS include decreased urine output, pallor and lethargy. A varying degree of renal insufficiency develops sometimes necessitating kidney dialysis or resulting in total renal failure. There is also increased risk of stroke and other complications.

C. Reservoirs:

Cattle are the reservoir of significant public health importance; however, other animals, such as goats, sheep, and deer, are known to be carriers. Humans serve as a reservoir for person-to-person transmission and in *Shigella* infections.

D. Mode(s) of Transmission:

Transmission occurs from consuming food or liquids, including water, contaminated with human or animal feces. Person-to-person transmission may occur via the fecal-oral route; including certain types of sexual contact (e.g., oral-anal contact).

E. Incubation Period:

In cases of *E. coli* 0157:H7, HUS occurs 2-14 days after onset of diarrhea.

F. Period of Communicability:

Varies with agent, for as long as the organism is excreted; typically 1 week in adults and up to 3 weeks in some children with *E. coli* 0157:H7. HUS case which is documented as enteric culture negative is assumed to be non-communicable.

G. Susceptibility and Resistance:

The infectious dose is very low and little is known about differences in susceptibility between serotypes with *E. coli*.

H. Treatment

Treatment of HUS is supportive including fluid and electrolyte replacement therapy and when appropriate kidney dialysis.

STANDARD CASE INVESTIGATION AND CONTROL METHODS

Standard investigation activities include the following:

- 1) Confirmation of diagnosis using case definition.
- 2) Collection of demographic data (birth date, county, sex, race/ethnicity)
- 3) Collection of clinical data (symptoms and laboratory results supporting case definition, onset date and time, and if available recovery date and time).
- 4) Determination of risk factors (e.g., association with daycare, hospital, restaurant or animals, travel history).
- 5) Investigation of epi-links among cases (cluster, household, co-workers, etc).

Standard investigation **includes** completion of the General Investigation Form and Enteric Supplemental Form. Further investigative activity should include:

- Every attempt should be made to collect a stool culture to identify the causative agent.
- A case of post-diarrheal HUS or TTP with no causative agent identified is considered a suspect case of Shiga toxin-producing *E. coli* and should be investigated as directed in the “Escherichia coli O157:H7 & Other Shiga-toxin Producing *E. coli* Disease Investigation Guidelines”.
- A case of post-diarrheal HUS or TTP with the causative agent identified should be investigated as directed by the disease investigation guideline associated with that agent.
- A single case of HUS may be an indicator of an outbreak since only about 8% of *E. coli* O157:H7 infections progress to HUS. It is important to identify other potential infections and obtain diagnostic tests. [ml]

DATA MANAGEMENT AND REPORTING TO THE KDHE

- A. Organize, collect and report data utilizing the “General Investigation Form” and “Enteric Disease Supplemental Form”.
- B. Report data electronically via KS-EDSS or by fax, include:
 - All essential data that was collected during the investigation, especially data that helps to confirm or classify a case.
 - All information collected on the supplemental form.

Note: If a patient meets the case definition for both Shiga toxin-producing *E. coli* (STEC) or Shigellosis and Hemolytic Uremic Syndrome (HUS), the case should be reported for each of the conditions. A case of post-diarrheal HUS or TTP with no causative agent identified is considered a suspect case of “Enterohemorrhagic *E. coli* Shiga Toxin positive (not serogrouped)”.

ADDITIONAL INFORMATION / REFERENCES

- A. **Treatment / Differential Diagnosis:** American Academy of Pediatrics. 2006 Red Book: Report of the Committee on Infectious Disease, 27th Edition. Illinois, Academy of Pediatrics, 2006.
- B. **Epidemiology, Investigation and Control:** Heymann. D., ed., Control of Communicable Diseases Manual, 18th Edition. Washington, DC, American Public Health Association, 2004.
- C. **Case Definitions:** CDC Division of Public Health Surveillance and Informatics, Available at: http://www.cdc.gov/ncphi/diss/nndss/casedef/case_definitions.htm
- D. **Quarantine and Isolation:** Kansas Community Containment Isolation/ Quarantine Toolbox Section III, Guidelines and Sample Legal Orders <http://www.waldcenter.org/Quarantine%20and%20Isolation%20Information%20for%20Health%20Officers.pdf>
- E. **Kansas Regulations/Statutes Related to Infectious Disease:** <http://www.kdheks.gov/epi/regulations.htm>
- F. **KDHE Foodborne Illness and Outbreak Investigation Manual:** Available at: http://www.kdheks.gov/epi/download/kansas_foodborne_illness_manual.pdf
- G. **KDHE Control of Enteric Disease Outbreaks in Childcare Facilities:** http://www.kdheks.gov/epi/download/Enteric_Disease_in_Day_care_centersver4.pdf
- H. **Animals in Public Places Compendium:** http://www.kdheks.gov/epi/human_animal_health.htm
- I. **KDHE Foodborne Illness Resources:** <http://www.kdheks.gov/epi/foodborne.htm>
- J. **Additional Information (CDC):** <http://www.cdc.gov/health/default.htm>

Kansas Disease Investigation Guidelines

General Investigation Form

Investigation Information		
Case Type: <input type="checkbox"/> Human Case <input type="checkbox"/> Non-human Case	Disease Name: _____	
Classification: <input type="checkbox"/> Suspect <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed	KS-EDSS Investigation ID: _____	
Outbreak: <input type="checkbox"/> Yes <input type="checkbox"/> No	Outbreak Name: _____	Outbreak #: _____
Onset Date: _____	Diagnosis Date: _____	Report Date: _____
Assigned to (Investigator): _____	Patient Died: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Patient Information		
Name Type: <input type="checkbox"/> Default/Common <input type="checkbox"/> Legal <input type="checkbox"/> Maiden <input type="checkbox"/> Nickname		
Last: _____	First: _____	Middle: _____
Street: _____	City/State: _____	Zip: _____
Evening Phone #: _____	Daytime Phone #: _____	
Sex: <input type="checkbox"/> Failure to Report <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Transexual <input type="checkbox"/> Unknown		
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown		
Hispanic / Latino Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Birth: _____	Age: _____	Age Unit: <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
Parent Information (if under 18)		
Last: _____	First: _____	Middle: _____
Street: _____	City/State: _____	Zip: _____
Evening Phone #: _____	Daytime Phone #: _____	
Work / Occupation or School / Grade		
Worksites / School: _____		
Occupations / Grade: _____		
Travel History		
1st	Destination: _____	Depart Date: _____ Return Date: _____
2nd	Destination: _____	Depart Date: _____ Return Date: _____
3rd	Destination: _____	Depart Date: _____ Return Date: _____
4th	Destination: _____	Depart Date: _____ Return Date: _____

Supplemental Laboratory Report Form

Lab Reports

Laboratory Name: _____

Lab Report Date: _____

Ordering Provider Name: _____

Phone: _____

Facility: _____

Specimen Accession Number: _____

Specimen Collection Date: _____

Organism Name: _____

Organism Species: _____

Organism Serogroup: _____

Organism Serotype: _____

PFGE Results

Pattern 1 KS: _____

Other State: _____

CDC: _____

Pattern 2 KS: _____

Other State: _____

CDC: _____

Pattern 3 KS: _____

Other State: _____

CDC: _____

Additional Results Information

Reported Test Name:

Coded Result:

Text Result:

Numeric Result:

Comments:

Supplemental Contact Form

Contacts

Last: _____ **First:** _____ **Middle:** _____

Street: _____ **City/State:** _____ **Zip:** _____

Evening Phone #: _____ **Daytime Phone #:** _____ **E-mail:** _____

Sex: Failure to Report Female Male Other Transexual Unknown

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Unknown

Hispanic / Latino Ethnicity: Yes No

Date of Birth: _____ **Age:** _____ **Age Unit:** Days Weeks Months Years

Worksites / School: _____

Occupations / Grade: _____

Exposure Information

Contact Type: Household Sexual Other: _____ **Partner / Cluster Code:** _____

Date of First Exposure: _____ **Date of Last Exposure:** _____ **Frequency:** _____

Nature of Exposure: _____ **Comments:** _____

Testing and Treatment Information

Clinic Code: _____ **Examination Date:** _____

Examination Test: _____ **Examination Result:** _____

Prophylaxis/empiric treatment date: _____ **Drug / Dosage:** _____

Provider (Name / Facility): _____

Disposition and Diagnosis Information

Initiation Date: _____ **Disposition Date:** _____ **Disposition:** _____

Diagnosis: _____ **Referral Type:** Patient Provider **Post-test Counseled :** Yes No

Currently Assigned To: _____ **Follow-up Date:** _____

Risk Factors

Pregnant: Yes No **If Yes, # of Weeks:** _____

Risk factors for complications in contact: None Pregnant Woman HIV Seropositive Unimmunized Index case is a super-spreader

Child younger than 5 Age > 65 Otherwise immunosuppressed (s/p transplant, high dose steroids, etc)

Enteric Disease Supplemental Form

Kansas Department of Health and Environment

Epidemiologic Case History

Condition	
<i>Calicivirus/Norwalk-like virus (norovirus)</i>	<i>Campylobacter Infection (Campylobacter spp.)</i>
<i>Cryptosporidiosis (Cryptosporidium parvum)</i>	<i>Enterohemorrhagic Escherichia coli (EHEC)</i>
<i>Enterohemorrhagic Escherichia coli O157:H7</i>	<i>Enterohemorrhagic Escherichia coli shiga toxin positive (not serogrouped)</i>
<i>Enterohemorrhagic Escherichia coli shiga toxin positive (serogroup non-O157)</i>	<i>Giardiasis (Giardia lamblia)</i>
<i>Salmonellosis (Salmonella spp.)</i>	<i>Shigellosis (Shigella spp.)</i>
<i>Cyclosporiasis (Cyclospora cayetanensis)</i>	<i>Hepatitis A</i>
<i>Listeriosis (Listeria monocytogenes)</i>	

* indicates required fields

Case Type*		Classification*					
<i>Human Case</i>	<i>Non Human Case</i>	<i>Confirmed</i>	<i>Not a Case</i>	<i>Probable</i>	<i>Suspect</i>	<i>Deleted</i>	<i>Unknown</i>

Supplemental Form Status				
<i>Not Done</i>	<i>Form Complete</i>	<i>Form in Progress</i>	<i>Form Approved</i>	<i>Form Sent to CDC</i>

Report Date*
mm/dd/yyyy

Date Investigation Started
mm/dd/yyyy

Patient Demographic Information

* indicates required fields

Last Name*	First Name*	Middle Name	Name Type*	Age
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Age Unit <i>Days Weeks Unknown Months Years</i>	Date of Birth <small>mm/dd/yyyy</small>
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Race* <small>(Check all that apply)</small>		
<i>American Indian or Alaska Native</i>	<i>Asian</i>	<i>Black or African American</i>
<i>Native Hawaiian or Other Pacific Islander</i>	<i>White</i>	<i>Unknown</i>

Ethnicity*		
<i>Hispanic or Latino</i>	<i>Not Hispanic or Latino</i>	<i>Unknown</i>

Sex*					
<i>Failure to Report</i>	<i>Female</i>	<i>Male</i>	<i>Other</i>	<i>Transexual</i>	<i>Unknown</i>

Street Address			
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City	County	State	Zip
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Evening Phone <small>###-###-####</small>	Daytime Phone <small>###-###-####</small>
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Occupation

High Risk Potential: <small>(Check all that apply)</small>	
<i>Contact to a confirmed case</i> _____	<i>Contact to a suspected case</i> _____
<i>Daycare attendee</i> _____	<i>Food handler</i> _____
<i>Direct patient care worker</i> _____	<i>Institutional resident or staff</i> _____
<i>Daycare worker</i> _____	<i>Animal handler</i> _____
<i>Other</i> _____	

If enrolled in day care, please complete the information below.

Name of Facility	Evening Phone <small>###-###-####</small>
-------------------------	---

Street Address		City
County	State	Zip

Person Providing Report

Name of Reporting Facility*

Clinical and Laboratory Data

Individual diagnosed with			Was a stool specimen collected?		
<i>Hemolytic Uremic Syndrome (HUS) Thrombotic Thrombocytopenic Purpura (TTP)</i>			<i>Yes No</i>		
Diarrhea?	Number of Stools	Blood in Stool?	Vomiting?		
<i>Yes No Unknown</i>	<i>0 - 2 3 - 10 11 and above</i>	<i>Yes No Unknown</i>	<i>Yes No Unknown</i>		
Nausea?	Abdominal Cramps?	Muscle Ache?	Other Symptoms?		
<i>Yes No Unknown</i>	<i>Yes No Unknown</i>	<i>Yes No Unknown</i>	<i>other</i> _____		
What was the first Symptom		Date of Onset <small>mm/dd/yyyy</small>	Time of Onset		

Clinical and Laboratory Data cont.

Fever? <i>Yes No Unknown</i>	If Yes, specify highest temperature:
--	---

Physician Information	
Was a physician consulted for this illness? <i>Yes (please complete the information below) No</i>	Name of physician:

Evening Phone ###-###-####	Street Address		
City	County	State	Zip

Antibiotic Information			
Was case treated with antibiotics anytime in the 14 days prior to illness? <i>Yes No Unknown</i>	Type of treatment/antibiotic	Reason for taking	Date started mm/dd/yyyy

Date completed mm/dd/yyyy	Was case treated with antibiotics for this illness? <i>Yes No Unknown</i>	Type of treatment:	Date Started: mm/dd/yyyy
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Date completed: mm/dd/yyyy	Was organism resistant to antibiotics? <i>Yes No Unknown</i>	If yes, specify resistance pattern:
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Is the patient on any medication or receiving any treatment which may suppress their immune system (i.e. Corticosteroids or Cancer Chemotherapy)? <i>Yes No Unknown</i>	If yes please specify medication or treatment:
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Did patient recover? <i>Yes No Unknown</i>	Recover Date mm/dd/yyyy	Recover Time
--	-----------------------------------	---------------------

Exposure/Transmission

Did anyone else (in your family ..) recently have similar symptoms? <i>Yes (please complete below) No Unknown</i>

Name	Age	Sex	Relationship to Case	Occupation	Symptoms	Date of Onset
						mm/dd/yyyy

Any restaurant, commercial food establishments, or group gatherings visited within the 7 days prior to onset of illness? <i>Yes (please complete below) No Unknown</i>
--

Name of Establishment	City, County, State	Foods eaten	Date of Exposure
			mm/dd/yyyy

Travel History

Did the patient Travel prior to the onset of illness?

Yes No Unknown

If yes, please complete below:

Where:	Departure Date: <small>mm/dd/yyyy</small>	Return Date: <small>mm/dd/yyyy</small>
Where:	Departure Date: <small>mm/dd/yyyy</small>	Return Date: <small>mm/dd/yyyy</small>

Water Exposure

Possible water sources:

(Check all that apply)

Municipal Water System _____
 Bottled Water _____
 Private Well _____
Rural Water System _____
 Other (specify): _____

Did patient drink water from other than a treated municipal system (i.e., stream, well)?

Yes No Unknown

Other Possible Exposure Information

Was there contact with pets or animals within 7 days prior to onset?

Yes No Unknown

If yes, please indicate below:

(Check all that apply)

Caged Birds *Cats* *Cattle* *Chickens* *Dogs* *Ducks*
Frogs *Goats* *Guinea Pigs* *Hamsters* *Horses* *Lizards*
Mice *Parakeets* *Pigeons* *Pigs* *Poultry* *Rabbits*
Rats *Sheep* *Snakes* *Turkeys* *Turtles* *Other* _____

Other Exposure Information

Other Birds?	If yes, please specify	Other Reptiles?	If yes, please specify
<i>Yes No Unknown</i>		<i>Yes No Unknown</i>	

Other Animals?	If yes, please specify
<i>Yes No Unknown</i>	

Were any of these animals ill near the time of onset

Yes No Unknown

If yes, please describe:

Where were the animals located?

(Check all that apply)

Home *Farm* *School* *Pet Store* *Zoo* *Petting Zoo* *Other* _____

Other Possible Exposure Information cont.

Within 7 days prior to onset of illness, did the patient participate in:

Activity	Participation	Date	Location
		mm/dd/yyyy	
Outdoor Activities			
Swimming			
Chlorinated Pool			
Wading Pool			
River/Lake/Pond			

Food History

Did case eat any of the following within 7 days prior to the onset of illness?

Food Product	Consumed	City, County, State	Variety or Brand(s)	Supplier	Supplier City
1. Chicken					
2. Hamburger					
3. Sausage					
4. Hot Dogs					
5. Lunch Meat					
6. Eggs					
7. Milk raw					
8. Milk past.					
8. Fresh juice					
10. Fresh berries					
11. Fresh melon					
12. Other fresh fruit					
13. Lettuce					
14. Alfalfa Sprouts					
Other fresh vegetables		Other Food Item 1		Other Food Item 2	

At what store(s) do you regularly shop for groceries?

Date: _____

Dear _____,

The stool sample for _____, collected on _____ has tested positive for the bacterial pathogen(s):

- E. Coli: O157:H7 Campylobacter Other _____
- Salmonella Shigella

The Following action(s) is necessary:

- None.
- Contact your Local Health Department at _____ for an additional interview.
- Inform your physician that your laboratory tests are positive if he/she is not aware of these results. He/she will decide if antibiotics need to be prescribed. If your physician decides not to treat you with antibiotics please remember that the bacteria may be transmitted to others as long it is present in your stool. This may persist for several weeks even though you may no longer have symptoms. It is important to note that frequent and thorough hand washing will minimize risk of transmission to others.
- You may not work in food handling, direct patient care or occupations involving the care of young children or the elderly until:
- You experience no diarrhea for 24 hours.
 - Your stool specimens test negative 2 consecutive times. (Stool samples should be collected 24 hours apart and no sooner than 48 hours after you last dose of antibiotics.)
 - The local health officer or the Secretary of Health and Environment issues an order allowing you to return to work.
- Your child may not attend school or daycare until:
- He/she experiences no diarrhea for 24 hours.
 - His/her stool specimens test negative 2 consecutive times. (Stool samples should be collected 24 hours apart and no sooner than 48 hours after your last dose of antibiotics.)

Sincerely,

Investigator Name, Title

Phone #

Address Line 1

Address Line 2

City, State Zip Code

Date: _____

Dear: _____,

I am writing to you in regards to some recent laboratory test results that you should have received. I work with the Local Health Department; as part of my job, I provide information and answer questions about certain diseases that are reportable to us.* I would like to speak to you about your laboratory tests and provide information to you as well as to obtain some additional information about your results. Everything we receive from you or your healthcare provider is **STRICTLY CONFIDENTIAL**. The purpose of us collecting this information is to educate patients and to collect information for public health planning and to support our disease prevention activities.

Please contact me at your earliest convenience so that we may discuss this matter further. If your health care provider has not yet discussed this with you, I would encourage you to make an appointment or call them as soon as possible.

I look forward to discussing this matter with you and will be happy to answer any questions that you may have. My telephone number is _____.
Thank you in advance for your assistance.

Sincerely,

*The Kansas Department of Health and Environment (KDHE) has the authority to define what diseases shall be regarded as dangerous to the public health and to require the reporting of such diseases. Under this authority KDHE has established regulations making certain diseases reportable (K.S.A. 65-118 and K.S.A. 65-128, and amendments thereto). These regulations outline reporting requirements and control measures that apply to both confirmed cases of such diseases and contacts of confirmed cases. Local health departments are required to collect information for the KDHE and implement control measures.

Date: _____

Dr: _____,

I am writing to you in regards of your patient, _____. The Health Department recently received notice that this patient may have been diagnosed with _____, which is a reportable disease under State rules and regulations. The Health Department routinely contacts patients with reportable diseases to gain more information, provide education, and make necessary referrals and support. In order to do this, I would like to speak to you regarding the laboratory results and risk history of this patient.

Please contact me at your earliest convenience so that we may obtain the information required for this report. If it is more convenient for you to fill out the report form on your own and send it to me, please feel free to do so. I have enclosed a copy of it with this letter. I would also like to remind you that during our investigation we may be contacting your patient directly, it is strongly recommended that you contact your patient to discuss this diagnosis and inform them of our investigation. All of the information that we obtain from either you or your patient is **STRICTLY CONFIDENTIAL**.

I look forward to discussing this matter with you and will be happy to answer any questions that you may have. My telephone number is _____.
Thank you in advance for your assistance.

Sincerely,

*The Kansas Department of Health and Environment (KDHE) has the authority to define what diseases shall be regarded as dangerous to the public health and to require the reporting of such diseases. Under this authority KDHE has established regulations making certain diseases reportable (K.S.A. 65-118 and K.S.A. 65-128, and amendments thereto). These regulations outline reporting requirements and control measures that apply to both confirmed cases of such diseases and contacts of confirmed cases. Local health departments are required to collect information for the KDHE and implement control measures.