Trichinellosis

Agency: ______
Investigator: ______ Phone number: ______

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: ______
First and middle name: ______
Maiden name: ______ Suffix: ______
Address line: ______
Zip: ______ City: ______
State: ______ County: ______
Phone: ( )- - Type: ______
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name: ______

Date of Birth: / / Estimated? ☐ Age: ______
Gender: ☐ Female ☐ Male ☐ Other ______
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name: ______
Parent/Guardian phone: ( )- - Type: ______

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name: ______
Exposure setting: ______
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: ______ Country: ______

Healthcare provider information

Last name: ______
First name: ______
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name: ______
Address line 1: ______
Address line 2: ______
Zip code: ______ City: ______
State: ______ County: ______
Phone : ( )- - Type: ______

LABORATORY FINDINGS

Laboratory: ______ Accession #: ______ Collection date: / /
Date received: / / Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Trichinella*** Type (e.g. serotype):

Laboratory: ______ Accession #: ______ Collection date: / /
Date received: / / Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Trichinella*** Type (e.g. serotype):

Laboratory: ______ Accession #: ______ Collection date: / /
Date received: / / Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Trichinella*** Type (e.g. serotype):

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____
Admission date: / / Discharge date: / / Days hospitalized: _____
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Fever: ☐ Yes ☐ No ☐ Unk Onset date: / / Highest known fever: C/F

Eosinophilla: ☐ Yes ☐ No ☐ Unk Absolute #: _____ Percent: _____

Periorbital edema: ☐ Yes ☐ No ☐ Unk **Myalgia:** ☐ Yes ☐ No ☐ Unk

OTHER LAB FINDINGS

Biopsy performed: ☐ Yes ☐ No ☐ Unk Date: / / Site: _____ Result: _____

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic: _____
Date started: / /
Dose: _____
Unit: ☐ mg ☐ ml ☐ IU
# of days: _____
# of times a day: _____
Route: _____

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Date started: / /
Dose: _____
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Date started: / /
Dose: _____
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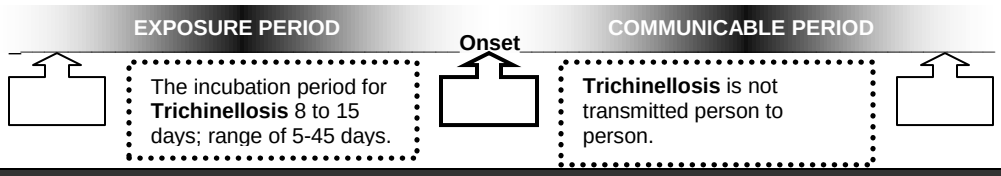
INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Dietary Information – *In the 45 days prior to onset of symptoms did the case consume the following:*

Meat and poultry

Pork: ☐ Yes ☐ No ☐ Unk

Pork type: ☐ Bacon ☐ Ham ☐ Sausage ☐ Chops ☐ Roast ☐ Wild Boar ☐ Other

List all brand names: _____

Obtained where: ☐ Butcher shop ☐ Hunted/Trapped ☐ Supermarket/Grocery store ☐ Direct from farm ☐ Restaurant /Eating establishment ☐ Unknown

Preparation: ☐ Dried jerky ☐ Marinated ☐ Smoked ☐ Ground ☐ No further processing ☐ Other

Cooking method: ☐ Broiled ☐ Fried ☐ Open-fire roasting ☐ Smoked ☐ Dehydrated ☐ Grilled ☐ Roasted ☐ Uncooked ☐ Unknown

From dates consumed: / / , / / To dates consumed: / / , / /

Meat other than pork: ☐ Yes ☐ No ☐ Unk

Meat type: ☐ Bear ☐ Hamburger ☐ Bison ☐ Venison ☐ Other

List all brand names:

Obtained where: ☐ Butcher shop ☐ Hunted/Trapped ☐ Supermarket/Grocery store ☐ Direct from farm ☐ Restaurant /Eating establishment ☐ Unknown

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From dates consumed: / / , / / To dates consumed: / / , / /

NOTES: