

TRICHINELLOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ___/___/____ Age: _____ years months Current Sex: Female Male Unknown

Is the patient deceased? No Unknown Yes Date of Death: ___/___/____

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (____)-____-____ Cell Phone: (____)-____-____ Work Phone: (____)-____-____ Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

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

INVESTIGATION SUMMARY

Investigation Start Date: ___/___/____ Investigation Status: Open Closed Investigator: _____

REPORTING SOURCE

Date of Report: ___/___/____ Reporting Source: _____

CLINICAL

Physician's Name: _____ Phone Number: (____)-____-____ Ext. _____

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name: _____

Admission Date: ___/___/____ Discharge Date: ___/___/____ Duration of Stay _____ day(s)

Diagnosis Date: ___/___/____ Illness Onset Date: ___/___/____ Illness End Date: ___/___/____

Age at Onset: _____ days hours minutes months unknown weeks years

Did the patient die from this illness? No Unknown Yes Date of Death: ___/___/____

EPIDEMIOLOGIC

Is this patient associated with a day care facility? No Unknown Yes Is this patient a food handler? No Unknown Yes

Is this case part of an outbreak? No Unknown Yes If yes, outbreak name: _____

Case Status: Confirmed Not a Case Probable Suspect Unknown MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General Comments: _____

JEFFERSON COUNTY SUPERVISOR REVIEW

Date Due: ___/___/____ Investigation ready for supervisor review: Reviewed (Complete) Reviewed (Incomplete)

Date investigation ready for supervisor review: ___/___/____ Reviewed (Not a case) Yes

Review comments (completed by supervisor): _____

SIGNS AND SYMPTOMS

Fever: No Unknown Yes Highest Temp: _____ °F Bloating: No Unknown Yes
 Diarrhea: No Unknown Yes No. of stools: _____ Vomiting: No Unknown Yes
 Bloody Stools: No Unknown Yes Weight Loss: No Unknown Yes
 Mucoid Stools: No Unknown Yes Malaise: No Unknown Yes
 Flatulence: No Unknown Yes Abdominal Pain: No Unknown Yes
 Other Symptoms: _____

EXPOSURES

What is the patient's primary occupation? _____ Name and location of employer: _____

In the **12 days** prior to onset of symptoms did patient have exposure to or contact with any of the following? *Please be specific.*

Institution for the mentally challenged: No Unknown Yes Date: ___/___/____ Location: _____
 Circumstances: _____

Nursing Home: No Unknown Yes Date: ___/___/____ Location: _____
 Circumstances: _____

Raw/unpasteurized milk or dairy products: No Unknown Yes Date: ___/___/____ Location: _____
 Circumstances: _____

Raw/unpasteurized juices (e.g.: apple cider): No Unknown Yes Date: ___/___/____ Location: _____
 Circumstances: _____

DAY CARE

Attend a day care center? No Unknown Yes Work at a day care center? No Unknown Yes
 Live with a day care center attendee? No Unknown Yes What is the name of the day care facility? _____
 What type of day care facility: Adult day health care Adult day social care Alzheimer's specific day care
Child care center Child care provided by friend, relative, neighbor In-home care giver
 Is food prepared at this facility? No Unknown Yes Does this facility care for diapered persons? No Unknown Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? No Unknown Yes
 What was the last date worked as a food handler after onset of illness? ___/___/____
 Where was the patient a foodhandler? _____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? No Unknown Yes Applicable incubation period for this illness is: **1 – 12 days**
 What was the purpose of travel? Business Migration (immigration to US) Other _____ Tourism Visiting relatives/friends
 Please specify the destination(s):
 Destination 1 Type: Domestic State/Territory: _____ International Country: _____
 Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/____ Departure Date: ___/___/____
 Destination 2 Type: Domestic State/Territory: _____ International Country: _____
 Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/____ Departure Date: ___/___/____

Destination 3 Type: Domestic State/Territory: _____ International Country: _____

Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/_____ Departure Date: ___/___/_____

If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? Do not use tap water Municipal, city, or county Other _____ Private well Unknown

If "Private Well", how was home well water treated?

Both filtered and disinfected Disinfected Filtered Neither filtered nor disinfected Unknown

What is the source of tap water at school/work? Do not use tap water Municipal, city, or county Other _____ Private well Unknown

If "Private Well", how was school/work well water treated?

Both filtered and disinfected Disinfected Filtered Neither filtered nor disinfected Unknown

Did the patient drink untreated water in the **12 days** prior to onset of illness (e.g., from a river while camping)? No Unknown Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **12 days** prior to illness? No Unknown Yes

What was the recreational water exposure type? (select all that apply)

Hot Spring Hot Tub-Whirlpool-Jacuzzi-Spa Interactive Fountain Lake-Pond-River-Stream
Ocean Other _____ Recreational Water Park Swimming Pool

If "Swimming Pool", please specify swimming pool type:

Camp Pool Hospital/Therapy Pool Hotel/Motel/Resort Vacation Pool
Kiddie/Wading Pool Municipal/Community Pool Neighborhood/subdivision/Apartment/Condo Pool
Other, specify _____ Private Club/Membership Pool Private Home Pool, not a kiddie/wading pool
School/College/University Pool Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come in contact with an animal? No Unknown Yes Applicable incubation period for this illness is : **1 – 12 days**

If yes, select type of animal: Cat Cattle Chicken Dog Goats Lizard
Rodent Sheep Turkey Turtle Unknown
Other, specify: _____

Name or location of animal contact: _____

Did a patient acquire a pet prior to onset of illness? No Unknown Yes

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

CSF leak Hodgkin's disease IVDU
Alcohol abuse Asthma Atherosclerotic cardiovascular disease (ASCVD)/CAD
Burns Cerebral vascular accident (CVA) stroke Chronic GI illness/diarrhea
Cirrhosis/liver failure Cochlear implant Current smoker
Deaf/profound hearing loss Diabetes mellitus (insulin): No Unk Yes Emphysema/COPD
Gastric surgery (type): _____ Heart failure Hematologic disease (type): _____
Immunodeficiency (type): _____ Immunoglobulin deficiency Immunosuppressive therapy (steroids, chemotherapy)
Leukemia Multiple myeloma Nephrotic Syndrome
None Organ transplant (organ): _____ Other liver disease (type): _____

Other malignancy (type): _____ Other prior illness (type): _____ Other renal disease (type): _____
 Peptic ulcer Renal failure/dialysis Sickle cell anemia
 Splenectomy/asplenia Systemic lupus erythematosus (SLE) Unknown

RELATED CASES

Does the patient know of any similarly ill persons? No Unknown Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: No Unknown Yes

Are the other cases related to this one? No, sporadic Unknown Yes, household Yes, not household Yes, outbreak

Note: Please enter name and Case ID of epi-linked case(s) in the ALNBS General Comments section.