TRICHINELLOSIS/TRICHINOSIS 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: ____________________________ ____________________________ ____________________________ ____________________________ ____________________________

PHA4 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): ____________________________ ____________________________ ____________________________ ____________________________

ADPH Trichinellosis Investigation Form (Rev. 02/2013)
### 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 food handler?  

### 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):  
<table>
<thead>
<tr>
<th>Destination Type</th>
<th>Domestic State/Territory</th>
<th>International Country</th>
<th>Mode of Travel</th>
<th>Arrival Date</th>
<th>Departure Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td></td>
<td></td>
<td>Airplane</td>
<td>__ / __ / __</td>
<td>__ / __ / __</td>
</tr>
<tr>
<td>2nd</td>
<td></td>
<td></td>
<td>Car</td>
<td>__ / __ / __</td>
<td>__ / __ / __</td>
</tr>
<tr>
<td>3rd</td>
<td></td>
<td></td>
<td>Cruise ship</td>
<td>__ / __ / __</td>
<td>__ / __ / __</td>
</tr>
<tr>
<td>4th</td>
<td></td>
<td></td>
<td>Train</td>
<td>__ / __ / __</td>
<td>__ / __ / __</td>
</tr>
</tbody>
</table>

If more than 3 destinations, specify details here:  

### 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  
- Alcohol abuse  
- Burns  
- Cirrhosis/liver failure  
- Deaf/profound hearing loss  
- Gastric surgery (type):  
- Immunodeficiency (type):  
- Leukemia  
- None  
- Other malignancy (type):  
- Peptic ulcer  
- Splenectomy/asplenia  

### 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.
**SIGNS AND SYMPTOMS**

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Unknown</th>
<th>Yes</th>
<th>If yes, specify amount:</th>
<th>Percentage</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the patient have Eosinophilia?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
<td></td>
<td></td>
<td>Highest Temp:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the patient have any of the following signs or symptoms of Trichinellosis:</td>
<td>Myalgia</td>
<td>Other</td>
<td>Periorbital edema</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUSPECTED FOOD**

<table>
<thead>
<tr>
<th>Question</th>
<th>Non-pork</th>
<th>Pork</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>What suspected food did patient eat?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CASE CLASSIFICATION**

1. Did the patient have fever (≥100.4°F), eosinophilia, myalgia, and/or periorbital edema? | No | Unknown | Yes |

2. Is one of the confirmatory laboratory criteria met? | Demonstration of *Trichinella* larvae in muscle tissue | Positive serologic test for *Trichinella* | No | Unknown | Yes |

3. In an outbreak setting where at least one case is laboratory confirmed, did the patient: | No | Unknown | Yes |

   - Share an epidemiologically implicated meal with a laboratory confirmed case or
   - Eat an epidemiologically implicated meat product and have either a: positive serologic test or clinically compatible illness.

Confirmed: 1 & 2

Outbreak Confirmed Case: 3