Local health departments should submit this report to the regional health department
Regional health departments should fax this report to 512-776-7616

Hookworm Investigation Form	**NBS Patient ID:**
Patient's name: ______________________________ Last First MI **Address:** ______________________________ **City:** ____________ **County:** __________ **Zip:**________ **Phone 1:** ( ) ________ **Phone 2:** ( ) __________ **Date of birth:** ____/____/____ **Age:** ____**Sex:** ☐Male ☐Female ☐Unk **Race:** ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American/Alaskan ☐Unknown ☐ Other: ____________ **Hispanic:** ☐ Yes ☐ No ☐ Unknown **Patient Occupation**:______________________________ **Parent/guardian's name**______________________________ **Country of origin**:____________ **Date of arrival in US:** ___/___/___	**Reported by:** ______________________________ **Agency:** ______________________________ **Phone: ( )**__________**Date reported:** ____/____/____ **Investigated by:** ______________________________ **Agency:** ______________________________ **Phone: ( )** ____________ **Email:**______________________________ **Investigation start date:** ____/____/____

CLINICAL DATA

Date of symptom onset: ___/___/___ **Illness end date**: ___/___/___ **Did patient die?** ☐ Yes, date of death: ___/___/___ ☐ No ☐ Unk

Signs and symptoms (Check all that apply):

☐ Cough ☐ Itchy Rash (especially on hands/feet) ☐ Loss of Appetite ☐ Nausea ☐ Abdominal Discomfort ☐ Diarrhea

☐ Fatigue ☐ Bloody Stool ☐ Pale Skin ☐ Anemia ☐ Other: ______________________________

Did the patient receive treatment? ☐ Yes ☐ No ☐ Unk Treatment start date: ___/___/___

If yes: ☐ Albendazole ☐ Mebendazole ☐ Pyrantel Pamoate ☐ Other ______________________________

Physician's name: ______________________________ **Physician's phone:** ( ) ______________

Was the patient hospitalized? ☐ Yes, name of hospital: ______________________________ ☐ No ☐ Unknown

If yes, Date of admission: ____/____/____ Date of discharge: ____/____/_____

LABORATORY

☐ Microscopic identification of *Ancylostoma* or *Necator* eggs in feces (O&P). Collection date: _____/_____/_____

☐ Microscopic identification of *Ancylostoma* or *Necator* larvae cultured from feces. Collection date: _____/_____/_____

☐ Identification of adult worms expelled after treatment. Collection date: _____/_____/_____

CONTACTS

How many people live in the patient's household? ________

Has anyone else in the household been treated for a helminthitic/parasitic infection? ☐ Yes ☐ No ☐ Unk

If yes, what type of infection? ______________________________

Are there any contacts ill with similar illness? ☐ Yes (If yes, list below.) ☐ No ☐ Unk

Last name: ____________________ First/ MI____________________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: ______________ Onset date: _______ Type of infection/symptoms: ____________________
____
Contact info same as case? ☐ Yes ☐ No Address: ______________________________ Phone: ( )__________

Last name: ____________________ First/ MI____________________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: ______________ Onset date: _______ Type of infection/symptoms: ____________________
____
Contact info same as case? ☐ Yes ☐ No Address: ______________________________ Phone: ( )__________

Last name: ____________________ First/ MI____________________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: ______________ Onset date: _______ Type of infection/symptoms: ____________________
____
Contact info same as case? ☐ Yes ☐ No Address: ______________________________ Phone: ( )__________

Hookworm Investigation Form Continued	**NBS Patient ID:**

EXPOSURE HISTORY

Has the patient or any member of the household lived or traveled internationally in the last 2 years? ☐ Yes ☐ No ☐ Unknown

If yes, where and when?

Country Visited	Dates Traveled	Traveler
		☐ Patient ☐ Household member
		☐ Patient ☐ Household member
		☐ Patient ☐ Household member
		☐ Patient ☐ Household member

Does the patient visit, work, or live on a farm? ☐ Yes ☐ No ☐ Unknown

If yes, where? _____

Does the patient have contact with soil (e.g. gardening, landscaping, child playing outside in dirt) either for work or recreation?

☐ Yes ☐ No ☐ Unknown If yes, describe: _____

_____

What type of plumbing system exists in the patient's home?

☐ City sewage disposal ☐ Septic Tank ☐ Other, please describe: _____

_____

Near the patient's home, work, or school are there areas potentially contaminated with human waste (e.g. outhouses, contaminated bodies of water)? ☐ Yes ☐ No ☐ Unknown

If Yes, please describe: _____

_____

_____

Does the patient routinely spend time outdoors barefoot? ☐ Yes ☐ No ☐ Unknown

COMMENTS