

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

Ascariasis Investigation Form	NBS Patient ID:	
Patient's name:	Reported by:	
Patient's name:Last First MI	Agency:	
Address: County: Zip:	Phone: () Date reported: / /	
Phone 1: () Phone 2: ()	Phone: ()Date reported:/	
Date of birth: Age: Sex: □Male □Female □Unk	Investigated by:	
Race: UWhite Black Asian Pacific Islander	Agonova	
□Native American/Alaskan □Unknown □ Other:	Agency:	
Hispanic: Yes No Unknown	Phone: ()	
Patient Occupation:	Email:	
Parent/guardian's name	Investigation start date://	
Country of origin: Date of arrival in US://		
	η	
Date of symptom onset:// Illness end date:// Did patient die? Ves, date of death:/_/ No Unk		
Signs and symptoms (Check all that apply):		
□ Indigestion □ Coughing/Wheezing □ Loss of Appetite □ Weight Loss □ Abdominal Pain □ Vomiting □ Fatigue		
□ Intestinal Obstruction/Bolus □ Other:		
Did the patient receive treatment? Yes No Unk Treatment start date://		
If yes: Albendazole Mebendazole Ivermectin Other		
Physician's name: Physician's phone: ()		
Was the patient hospitalized? Yes, name of hospital:		
If yes, Date of admission:/ Date of discharge:/		
LABORATORY		
□ Microscopic identification of eggs in feces (O&P). Collection date://		
□ Microscopic identification of Ascaris larvae from sputum or gastric washings. Collection date://		
□ Identification of adult worms passed from the nose, mouth, or anus. Collection date://		
□ Diagnostic imaging showing the presence of worms. Date image taken://		
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: T	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: T	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: T	Type of infection/symptoms:	
Contact info same as case? Yes No Address:	Phone: ()	



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Ascariasis 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 ON OUNKNOWN			
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 □ Unk	nown		
If yes, where?			
Does the patient have contact with soil (e.g. gardening, landscaping, o	hild playing outside in dirt) either	for work or recreation?	
□ Yes □ No □ Unknown If yes, describe:			
What turns of plumbing system sylicits in the national home?			
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:			
COMMENTS			