

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

Trichuriasis Investigation Form	NBS Patient ID:	
Detication and a	Reported by:	
Patient's name:	Agency:	
Address:	Phone: ( ) Date reported: / /	
City: Zip: Zip:	Priorie: ( )	
Phone 1: ( ) Phone 2: ( )	Investigated by:	
Date of birth:      //Age:      Sex:       □Male       □Female       □Unk         Race:       □White       □Black       □Asian       □Pacific Islander	Agency:	
□Native American/Alaskan □Unknown □ Other:	Phone: ( )	
Hispanic: □ Yes □ No □ Unknown	Email:	
Patient Occupation:		
Parent/guardian's name	Investigation start date://	
Country of origin: Date of arrival in US://	Investigation completed 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):		
☐ Frequent Painful Passage of Stool ☐ Bloody stool ☐ Mucousy Stool ☐ Rectal Prolapse ☐ Anemia ☐ Growth Retardation		
□ Eosinophilia □ Other:		
Did the patient receive treatment? ☐ Yes ☐ No ☐ Unk		
If yes:   Albendazole   Mebendazole   Ivermectin   Other   Distriction of the state		
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 <i>Trichuria</i> eggs or adult worms in feces (O&P). Collection date:/		
☐ Identification of adult <i>Trichuria</i> worms during sigmoidoscopy, proctoscopy, or colonoscopy. Surgery date:/		
☐ Identification of adult worms on prolapsed rectal mucosa. Identification 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		
Relationship to case: Onset date: Ty		
Contact info same as case? ☐ Yes ☐ No Address:	Phone: ( )	
Last name: First/ MI	•	
Relationship to case: Onset date: Ty	ype of infection/symptoms:	
Contact info same as case?   Yes  No Address:	Phone: ( )	
Last name:First/ MI	Age: <b>Sex:</b> □Male □Female □Unk	
Relationship to case: Onset date: Ty	ype of infection/symptoms:	
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Trichuriasis 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 ☐ Unk	nown		
If yes, where?		·	
Does the patient have contact with soil (e.g. gardening, landscaping, c	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)?			
If Yes, please describe:			
COMMENTS			

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