

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

Local ID Number _____

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

TRICHINOSIS CASE REPORT

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence			Apartment/Unit Number		
City/Town		State	Zip Code		
Census Tract	County of Residence		Country		
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone/Pager		Work/School Telephone	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
E-mail Address			Other Electronic Contact Information		
Work/School Location			Work/School Contact		
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Occupation Setting (see list on page 5)			Other Describe/Specify		
Occupation (see list on page 5)			Other Describe/Specify		
*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.					
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

First three letters of patient's last name:

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SIGNS AND SYMPTOMS

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset Date (mm/dd/yyyy)	Date First Sought Medical Care (mm/dd/yyyy)
Signs and Symptoms	Yes No Unk	If Yes, Specify as Noted
Eosinophilia (EM)		Absolute number (#) Percentage (%)
Fever		Highest temperature (specify °F/°C)
Periorbital edema		
Myalgia		
Other signs / symptoms (specify)		

HOSPITALIZATION

Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, how many total hospital nights?
If there were any ER or hospital stays related to this illness, specify details below.		

HOSPITALIZATION - DETAILS

Hospital Name 1	Street Address		Admit Date (mm/dd/yyyy)	
	City		Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Discharge Diagnosis
Hospital Name 2	Street Address		Admit Date (mm/dd/yyyy)	
	City		Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Discharge Diagnosis

OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Muscle <input type="checkbox"/> Other: _____ If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.	Type of Test <input type="checkbox"/> Trichinella sp. serology <input type="checkbox"/> Muscle biopsy <input type="checkbox"/> Other: _____	Collection Date (mm/dd/yyyy)
	Result	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal
	Laboratory Name	Telephone Number
Specimen Type 2 <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Muscle <input type="checkbox"/> Other: _____ If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.	Type of Test <input type="checkbox"/> Trichinella sp. serology <input type="checkbox"/> Muscle biopsy <input type="checkbox"/> Other: _____	Collection Date (mm/dd/yyyy)
	Result	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal
	Laboratory Name	Telephone Number

First three letters of patient's last name:

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EPIDEMIOLOGIC INFORMATION

FOOD HISTORY

Did patient eat pork?
Yes No Unk
 If Yes, specify source below.

Source	Yes	No	Unk	If Yes, Specify as Noted
Retail store / restaurant				Date Consumed (mm/dd/yyyy)
Pork from farm-raised pig				Date Consumed (mm/dd/yyyy)
Wild pig				Date Consumed (mm/dd/yyyy)
Other source				Source _____ Date Consumed (mm/dd/yyyy)

Did patient eat other meat (non-pork)?
Yes No Unk
 If Yes, specify source below.

Source	Yes	No	Unk	If Yes, Specify as Noted
Bear meat				Date Consumed (mm/dd/yyyy)
Hamburger (ground meat)				Date Consumed (mm/dd/yyyy)
Other meat				Type of Meat _____ Date Consumed (mm/dd/yyyy)
Unspecified meat				Date Consumed (mm/dd/yyyy)

List Any Suspected Meat / Food Items

Was meat tested and evidence of larvae found?
Larvae identified Larvae not identified Not identified Unk

Where was the suspected meat obtained?
Supermarket / grocery store Butcher shop Restaurant or other public eating establishment Direct from farm
Hunted or trapped Unk Other: _____

What preparation or further processing was done after purchase?
No further processing Ground (i.e., hamburger) Smoked Dried (jerky) Marinated Unk Other: _____

Method of cooking?
Uncooked Fried Open-fire roasting BBQ Unk Other cooking method: _____

CONTACTS / OTHER ILL PERSONS

Any contacts with similar illness (including household contacts)?
Yes No Unk
 If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	
Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	

First three letters of patient's last name:

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NOTES / REMARKS

REPORTING AGENCY

<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
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First Reported By
 Clinician Laboratory Other (specify): _____

EPIDEMIOLOGICAL LINKAGE

<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Contact Name / Case Number</i>
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DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
 Confirmed Probable Suspect

STATE USE ONLY

State Case Classification
 Confirmed Not a case Need additional information

CASE DEFINITION

TRICHINOSIS (2010)

CLINICAL DESCRIPTION

A disease caused by ingestion of *Trichinella* larvae. The disease has variable clinical manifestations. Common signs and symptoms among symptomatic persons include eosinophilia, fever, myalgia, and periorbital edema.

LABORATORY CRITERIA FOR DIAGNOSIS

- Demonstration of *Trichinella* larvae in tissue obtained by muscle biopsy, or
- Positive serologic test for *Trichinella*

CASE CLASSIFICATION

Confirmed: a clinically compatible case that is laboratory confirmed

COMMENT

In an outbreak setting, at least one case must be laboratory confirmed. Associated cases should be reported as confirmed if the patient shared an epidemiologically implicated meal or ate an epidemiologically implicated meat product and has either a positive serologic test for trichinosis or a clinically compatible illness.

RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • Adult film actor/actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker 	<ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other/unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent/guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Volunteer • Other • Refused • Unknown