TRICHINOSIS SURVEILLANCE CASE REPORT

Form Approved
OMB NO. 0920-0009

PERSONAL DATA

State Reporting: ☐☐ State abbreviation

First four letters of last name: ☐☐☐☐

Age: ☐☐

Sex: ☐ Male ☐ Female

Date of birth: ☐☐ Mo ☐☐ Day ☐☐ Yr

Race/Ethnicity:

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Unknown
☐ Asian ☐ Hispanic or Latino ☐ White

County:

Physician's Name:

Physician's Phone: ☐☐☐ — ☐☐☐ — ☐☐☐☐

DIAGNOSTIC DATA

DATE OF ONSET OF ILLNESS: ☐☐ Mo ☐☐ Day ☐☐ Yr

OUTCOME: ☐ Recovered ☐ Died ☐ Unknown

SIGNS AND SYMPTOMS:

Eosinophilia: ☐ Yes ☐ Not Done ☐ No ☐ Unknown
Specify absolute number or percentage:
(#) _____ or (%) _____

Fever: ☐ Yes ☐ Unknown ☐ No
Specify temperature:
_____

Periorbital edema: ☐ Yes ☐ Unknown ☐ No

Myalgia: ☐ Yes ☐ Unknown ☐ No

MUSCLE BIOPSY:
☐ Positive
☐ Negative
☐ Not Done

SEROLOGIC FINDINGS: ☐ Positive ☐ Negative ☐ Not Done ☐ Unknown

Test type (specify): _____

Date of test: ☐☐ Mo ☐☐ Day ☐☐ Yr Test results: ☐ Positive ☐ Negative ☐ Unequivocal ☐ Unknown

Date of test: ☐☐ Mo ☐☐ Day ☐☐ Yr Test results: ☐ Positive ☐ Negative ☐ Unequivocal ☐ Unknown

EPIDEMIOLOGIC DATA

SUSPECT FOOD:

☐ Pork (specify type below):
- ☐ Store bought pork
- ☐ Pork from farm-raised pig
- ☐ Wild boar
- ☐ Other (specify): _____
- ☐ Not specified

☐ Non Pork (specify type below):
- ☐ Bear meat
- ☐ Hamburger (ground meat)
- ☐ Other (specify): _____
- ☐ Not specified

☐ Unknown

DATE CONSUMED: ☐☐ Mo ☐☐ Day ☐☐ Yr

LARVAE IN SUSPECT FOOD:
☐ Not examined ☐ Present
☐ Absent ☐ Unknown

WHERE MEAT OBTAINED:
- ☐ Supermarket/grocery store
- ☐ Butcher shop
- ☐ Restaurant or other public eating establishment
- ☐ Direct from farm
- ☐ Hunted or trapped
- ☐ Other (specify): _____
- ☐ Unknown

PREPARATION AFTER PURCHASE FURTHER PROCESSING:
- ☐ No further processing
- ☐ Ground (i.e., hamburger)
- ☐ Smoked
- ☐ Dried jerky
- ☐ Marinated
- ☐ Other (specify): _____
- ☐ Unknown

METHOD OF COOKING:
- ☐ Uncooked
- ☐ Fried
- ☐ Open-fire roasting/BBQ
- ☐ Other cooking method (specify): _____
- ☐ Unknown

PATIENT'S OCCUPATION:

RELATED CASES: ☐ Yes ☐ No ☐ Unknown

COMMENTS AND ADDITIONAL DATA

Investigator name and title:

Date form completed:

of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).