NEW WORLD SCREWWORM (NWS) CASE REPORT

Department of Health and Human Services, Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA, 30329
Complete the form electronically using Adobe Acrobat. Contact newworldscrewworm@cdc.gov for submission instructions.

Required fields indicated by an asterisk (*)

*Case ID (Local Record ID): _____ *Person ID (Local Subject ID): _____ *National reporting jurisdiction: _____

*Case Classification: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a Case

Date first submitted to CDC (*mm/dd/yyyy*):_____/_____/_____

Earliest date of report to a public health agency (*mm/dd/yyyy*): ____/ ____/ _____

Earliest specimen collection date associated with a positive laboratory result (*mm/dd/yyyy*): ____/ ____/ _____

Earliest result date of a positive laboratory result (*mm/dd/yyyy*): ____/ ____/ _____

CASE DEMOGRAPHIC INFORMATION

Age: _____ Age units: ☐ yrs. ☐ mos. ☐ wks. ☐ days Date of Birth (*mm/dd/yyyy*): ____/ ____/ _____

Sex: ☐ Male ☐ Female ☐ Unknown

Race (*select all that apply*):

☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Asian
☐ Black or African American
☐ White
☐ Unknown
☐ Other, specify:_____
☐ Refused to answer

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Country of residence: _____ U.S. county of residence: _____

U.S. state of residence: _____ Zip code: _____

CASE HISTORY

Is the person currently employed? ☐ Yes ☐ No ☐ Unknown

If yes, what kind of work does the person do? (list all reported):_____

If yes, what kind of business or industry does the person work in? (list all reported):_____

Does the person have any of the following type(s) of disabilities:

	Yes	No	Unknown		Yes	No	Unknown
Vision (blindness, serious difficulty seeing even when wearing glasses)	☐	☐	☐	Difficulty performing personal care activity	☐	☐	☐
Hearing (serious difficulty hearing or deafness)	☐	☐	☐	Impaired cognition (serious difficulty such as concentrating, remembering, or making decisions due to a physical, mental, or emotional condition)	☐	☐	☐
Communication (difficulty understanding others or being understood in your usual language)	☐	☐	☐	Impaired mobility (serious difficulty walking or climbing stairs)	☐	☐	☐
Functionally dependent (e.g., difficultly doing errands alone)	☐	☐	☐	Intellectual disability (intellectual developmental disorder)	☐	☐	☐

At the time of the diagnosis, was the person immunocompromised? ☐ Yes ☐ No ☐ Unknown

If yes, specify the condition(s): _____

Did the person have recent history (e.g., in the two weeks prior to symptom onset) of unhealed wounds, open sores, or were they recovering from surgery? ☐ Yes ☐ No ☐ Unknown

CLINICAL INFORMATION

Did the person have any signs or symptoms consistent with an infestation? ☐ Yes ☐ No ☐ Unknown

If yes, earliest date of onset of signs or symptoms (*mm/dd/yyyy*): ___/_____/ _____

Did the person have any of the following signs or symptoms?

	Yes	No	Unknown		Yes	No	Unknown
Skin lesion, wound, or sore that worsened over time	☐	☐	☐	Sensation of movement	☐	☐	☐
Pain	☐	☐	☐	Visible larvae or maggots	☐	☐	☐
Swelling	☐	☐	☐	Nosebleed	☐	☐	☐
Discharge or bleeding	☐	☐	☐	Other	☐	☐	☐
Foul odor	☐	☐	☐	If other, specify: _____			

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CLINICAL INFORMATION, continued

Was the person's infestation in (*select all that apply*): ☐ Wound ☐ Body orifice (mucous membrane) ☐ Surgical site

Where on the person's body was the infestation? _____

What was the earliest date that the infestation was identified by a clinician as the final, suspected or most likely diagnosis? (*mm/dd/yyyy):* ___/____/_____

Was the infestation treated by removal of larvae from the infestation? ☐ Yes ☐ No ☐ Unknown

If yes, date treatment started (*mm/dd/yyyy*): ___/____/_____

List any other treatment(s) for this infestation: _____

Were there any larvae that fell out of or were removed from the person's infestation that were not collected by a healthcare provider? ☐ Yes ☐ No ☐ Unknown

Was the person admitted to the hospital for this illness? ☐ Yes ☐ No ☐ Unknown

If the person was admitted to the hospital for this illness more than once, enter information for the first hospitalization.

If yes, date of hospital admission (*mm/dd/yyyy*):_____/_____/ _____ Days hospitalized for this illness: ____

If yes, date of hospital discharge (*mm/dd/yyyy*):_____/_____/ _____

Is the person deceased? ☐ Yes ☐ No ☐ Unknown

If yes, date of death (*mm/dd/yyyy)*: _____/_____/ _____

If yes, is the person's death associated with NWS infestation? ☐ Yes ☐ No ☐ Unknown

EPIDEMIOLOGIC INFORMATION

In the 10 days **before** symptom onset, where did the person reside (spend at least one night)? (*select all that apply*):

Note: Congregate living settings are facilities (not private residences) where people who are not related reside in close proximity and share at least one common room, such as a sleeping room, kitchen, bathroom, or living room.

☐ Private residence in a long-term arrangement (i.e., more than two weeks)	☐ Hotel/motel or vacation rental in a long-term arrangement (i.e., more than two weeks)	☐ Private residence in a short-term arrangement (i.e., two weeks or less)
☐ Hotel/motel or vacation rental in a short term-arrangement (i.e., two weeks or less)	☐ Shelter or safe haven (congregate setting)	☐ Temporary, non-congregate housing provided by charity or government program (e.g., transitional housing, hotel/motel)
☐ Structure or vehicle not meant for human habitation	☐ Vehicle meant for human habitation (e.g., RV)	☐ Outside or open air (e.g., tent, bus shelter), part of an established encampment
☐ Outside or open air (e.g., tent, bus shelter), not part of an established encampment	☐ Agricultural (e.g., livestock, farm) worker housing	☐ Military congregate housing (e.g., barracks)
☐ Other congregate housing for workers	☐ School/university congregate housing (e.g., dormitories	☐ Federal adult correctional facility
☐ State adult correctional facility	☐ Local adult jail/detention facility	☐ Juvenile correctional/detention facility
☐ Other correctional/detention facility (e.g., border detention facility	☐ Mental/Behavioral/Substance use treatment facility	☐ Long term care facility (e.g., skilled nursing facility, nursing home, assisted living)
☐ Other inpatient medical facility	☐ Group home or residential facility not provided by employer or school (e.g., recovery house)	☐ Unknown
☐ Other, specify living situation(s): _____		☐ Declined to respond

Travel

During the 10 days **before** symptom onset:

Did the person spend time outside the United States? ☐ Yes ☐ No ☐ Unknown

Did the person spend time within the United States, but outside their county of residence? ☐ Yes ☐ No ☐ Unknown

Travel section continues on next page

FORM CONTINUES ON NEXT PAGE

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EPIDEMIOLOGIC INFORMATION, continued

Travel, continued

If the person reported travel, enter each travel destination:

Instructions for entering travel information:

- *If the person traveled to the same destination on more than one consecutive day, (e.g., traveled to the same county every day), enter this as one destination; enter the earliest date of arrival as the Date of Arrival and the most recent date of departure as the Date of Departure.*

International country of recent travel	U.S. state of recent travel	U.S. county of recent travel	Date of Arrival (*mm/dd/yyyy*)	Date of Departure (*mm/dd/yyyy*)
_____	_____	_____	___/___/_____	___/___/_____
_____	_____	_____	___/___/_____	___/___/_____
_____	_____	_____	___/___/_____	___/___/_____
_____	_____	_____	___/___/_____	___/___/_____
_____	_____	_____	___/___/_____	___/___/_____

Exposure

During the 10 days **before** symptom onset, was the person exposed to any of the following:

Include the following information in the **Details** field for each exposure:

- **Animals** or **locations with animals:** type of animal(s) and if the animal(s) showed evidence of an infestation (e.g. head shaking, irritated behavior, smell of decay, presence of fly larvae/maggots in wounds)
- **A person with an infestation:** details on contact type (e.g., travel companion, coworker, household member) and case identifier number, if available.

Instructions for entering exposure information:

- *If the exposure started prior to the 10 days before symptom onset, enter the known or estimated start date if available. If not available, enter the date 10 days before the date of symptom onset as the Exposure Start Date.*
- *If the same exposure occurred on more than one consecutive day, (e.g., exposure to the same domestic animal every day), enter this as one exposure; enter the earliest exposure date as the Exposure Start Date and the most recent exposure date as the Exposure End Date.*

Exposure	**Yes**	**No**	**Unknown**	**Exposure Start Date** ***(mm/dd/yyyy)***	**Exposure End Date** ***(mm/dd/yyyy)***	**Details**
Animals						
Livestock (e.g., cattle, goats, sheep, pigs, horses, or poultry)	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____
Domestic animals not considered livestock (e.g., dogs, cats, companion animals, pets)	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____
Wildlife (e.g., deer)	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____
Locations with Animals						
Farm or ranch with animals (e.g. visiting, working, or living)	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____
Fair or event with animals (e.g., visiting or working)	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____
Zoo, including petting zoo (e.g., visiting or working)	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____
Animal shelter	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____
Hunting location	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____
A person with an infestation	☐	☐	☐	___/___/_____ ___/___/_____	___/___/_____ ___/___/_____	_____ _____

Additional exposures entered on next page

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Exposures, continued

Enter any additional exposures of note

Other exposures	Yes	No	Unknown	Exposure Start Date *(mm/dd/yyyy)*	Exposure End Date *(mm/dd/yyyy)*	Details
Specify:_____	☐	☐	☐	___/___/_____	___/___/_____	_____
Specify:_____	☐	☐	☐	___/___/_____	___/___/_____	_____
Specify:_____	☐	☐	☐	___/___/_____	___/___/_____	_____

LABORATORY TESTING

Enter laboratory testing conducted for NWS identification. Include confirmatory laboratory testing for NWS (i.e., laboratory testing conducted by CDC DPDx, USDA NVSL, or other laboratory with training to identify NWS larvae).

Test 1

Date of specimen collection (*mm/dd/yyyy*): ____/_____/_____ Date of result (*mm/dd/yyyy*): ____/_____/_____

Specimen type (*select all that apply*): ☐ Whole Organism ☐ Image or Video ☐ Other, specify:_____

Select the laboratory that conducted the testing: ☐ CDC DPDx ☐ USDA NVSL ☐ Public health laboratory ☐ Clinical laboratory ☐ Commercial reference laboratory (e.g., ARUP, Quest) ☐ Other laboratory, specify: _____

Test Type: ☐ Ova/parasite examination (parasite morphological identification) ☐ Other, specify_____

Test Result: ☐ *Cochliomyia hominivorax* ☐ Fly larva ☐ Arthropod ☐ Unable to identify ☐ No parasite found ☐ Other, specify: _____

What stage(s) of larvae were identified? (*select all that apply*): ☐ 1st instar ☐ 2nd instar ☐ 3rd instar ☐ Unknown ☐ Not reported

Test 2

Date of specimen collection (*mm/dd/yyyy*): ____/_____/_____ Date of result (*mm/dd/yyyy*): ____/_____/_____

Specimen type (*select all that apply*): ☐ Whole Organism ☐ Image or Video ☐ Other, specify:_____

Select the laboratory that conducted the testing: ☐ CDC DPDx ☐ USDA NVSL ☐ Public health laboratory ☐ Clinical laboratory ☐ Commercial reference laboratory (e.g., ARUP, Quest) ☐ Other laboratory, specify: _____

Test Type: ☐ Ova parasite examination (parasite morphological identification) ☐ Other, specify_____

Test Result: ☐ *Cochliomyia hominivorax* ☐ Fly larva ☐ Arthropod ☐ Unable to identify ☐ No parasite found ☐ Other, specify: _____

What stage(s) of larvae were identified? (*select all that apply*): ☐ 1st instar ☐ 2nd instar ☐ 3rd instar ☐ Unknown ☐ Not reported

Test 3

Date of specimen collection (*mm/dd/yyyy*): ____/_____/_____ Date of result (*mm/dd/yyyy*): ____/_____/_____

Specimen type (*select all that apply*): ☐ Whole Organism ☐ Image or Video ☐ Other, specify:_____

Select the laboratory that conducted the testing: ☐ CDC DPDx ☐ USDA NVSL ☐ Public health laboratory ☐ Clinical laboratory ☐ Commercial reference laboratory (e.g., ARUP, Quest) ☐ Other laboratory, specify: _____

Test Type: ☐ Ova/parasite examination (parasite morphological identification) ☐ Other, specify_____

Test Result: ☐ *Cochliomyia hominivorax* ☐ Fly larva ☐ Arthropod ☐ Unable to identify ☐ No parasite found ☐ Other, specify: _____

What stage(s) of larvae were identified? (*select all that apply*): ☐ 1st instar ☐ 2nd instar ☐ 3rd instar ☐ Unknown ☐ Not reported

Comments:

Contact newworldscrewworm@cdc.gov for instructions for submission to CDC.