TEXAS Department of State Health Services

Echinococcosis Case Investigation

PLEASE PRINT LEGIBLY

NBS Patient ID: ___________________________

Patient Information

Last Name: ______________________________ First Name________________________________

Date of Birth: _____/______/_____ Age______ Sex: ☐ Male ☐ Female ☐ Unknown

Street Address: ______________________________ City, State, Zip: ______________________________

Patient Phone: ______________________________ County of Residence: ________________________

Race: ☐ Asian ☐ American Indian/Alaskan Native
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Unknown ☐ Other: ___________________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown Country of birth: ______________________________

Length of time living at present address: ____

Physician/Provider Information

Physician:______________________________ Address____

City, State, Zip:__________________________ Phone:___________________ Fax:___________________

Clinical Information and Treatment

Was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Emergency room visit only ☐ Unknown

If yes, provide name of hospital:____

Dates of hospitalization: Admission ____/____/______ Discharge ____/____/______

Is the patient deceased? ☐ Yes ☐ No ☐ Unknown

If yes, provide date of death:__________________________ *(submit documentation if due to echinococcosis)*

Was the patient pregnant during illness? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Was the patient treated for this illness? ☐ Yes ☐ No ☐ Unknown ☐ Not completed

If yes, describe treatment:____

Date of Illness Onset: ____/____/______ ☐ Asymptomatic

Signs and Symptoms

Symptom	Yes	No	Unknown
Fever	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown
Cough	☐ Yes	☐ No	☐ Unknown
Nausea/Vomiting	☐ Yes	☐ No	☐ Unknown
Weight Loss	☐ Yes	☐ No	☐ Unknown
Malaise	☐ Yes	☐ No	☐ Unknown
Abdominal pain	☐ Yes	☐ No	☐ Unknown
Chest pain	☐ Yes	☐ No	☐ Unknown
Rash	☐ Yes	☐ No	☐ Unknown
Liver failure	☐ Yes	☐ No	☐ Unknown
Eosinophilia	☐ Yes	☐ No	☐ Unknown
Anaphylactic Shock	☐ Yes	☐ No	☐ Unknown
Neurological symptoms	☐ Yes	☐ No	☐ Unknown

Exposures/Risk Factors

In the **1-5 years** prior to illness onset, did the patient:

Travel outside of their state of residence? ☐ Yes ☐ No ☐ Unknown

If yes, where_________________________________ Dates: ____________________________

Have contact with animals (including pets, livestock etc.)? ☐ Yes ☐ No ☐ Unknown

If yes, describe the animal(s) and type of contact: ____

NBS Patient ID: ______________________ Patient Name: ________________________________

Have contact with animal waste / manure? ☐ Yes ☐ No ☐ Unknown

Drink from, play/swim in any of the following water sources?
☐ Well ☐ Secondary / irrigation ☐ Hose / sprinkler ☐ Natural water (eg. river, lake, pond, spring)
☐ Bathtub where pets have bathed ☐ Unknown ☐ None ☐ Other: ______________________________
If yes, provide dates and details:____

Consume undercooked meat? ☐ Yes ☐ No ☐ Unknown
If yes, what was the product? __________________________________ Date consumed: ____/____/____

Consume unwashed fruits/vegetables? ☐ Yes ☐ No ☐ Unknown
If yes, what was the product? __________________________________ Date consumed: ____/____/____

Does the patient know anyone ill with similar symptoms? ☐ Yes ☐ No ☐ Unknown
If yes, provide details: ____

Laboratory Findings

Diagnostic Test	**Date Collected**	**Titer/Value**	**Interpretation**
Serology #1			
Serology #2			
Imaging Techniques	**Date Performed**	**Results**	**Interpretation**
Computerized tomography			
Magnetic resonance imaging			
Ultrasonography			
Organism Identification	**Date Collected**	**Source**	**Interpretation**
PCR			
Histopathology/parasitology			

Comments or Other Pertinent Epidemiological Data:

Date First Reported: ____/____/______ Investigation: Started ____/____/_____ Completed ____/____/_____
Reporting Facility:____
Name of Investigator:____________________________________ *(Please print clearly)*
Agency:____ *(Please do not abbreviate)*
Phone:______________________________ E-Mail:____