TEXAS Department of State Health Services

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:**
Patient's name: ______________________ (Last / First / MI)	**Reported by:** ______________________
Address: ______________________	**Agency:** ______________________
City: ________ **County:** ________ **Zip:** ________	**Phone:** ( ) ________ **Date reported:** ___/___/___
Phone 1: ( ) ________ **Phone 2:** ( ) ________	**Investigated by:** ______________________
Date of birth: ___/___/___ **Age:** ___ **Sex:** ☐Male ☐Female ☐Unk	**Agency:** ______________________
Race: ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American/Alaskan ☐Unknown ☐ Other: ________	**Phone:** ( ) ________
Hispanic: ☐ Yes ☐ No ☐ Unknown	**Email:** ______________________
Patient Occupation: ______________________	**Investigation start date:** ___/___/___
Parent/guardian's name ______________________	**Investigation completed date:** ___/___/___
Country of origin: ________ **Date of arrival in US:** ___/___/___	

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 ______________________

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 *Trichuria* eggs or adult worms in feces (O&P). Collection date: ___/___/___

☐ Identification of adult *Trichuria* 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 ________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: ________ Onset date: ________ Type of infection/symptoms: ________
Contact info same as case? ☐ Yes ☐ No Address: ________ Phone: ( ) ________

Last name: ________ First/ MI ________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: ________ Onset date: ________ Type of infection/symptoms: ________
Contact info same as case? ☐ Yes ☐ No Address: ________ Phone: ( ) ________

Last name: ________ First/ MI ________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: ________ Onset date: ________ Type of infection/symptoms: ________
Contact info same as case? ☐ Yes ☐ No Address: ________ Phone: ( ) ________

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 ☐ Unknown

If yes, where? _____

Does the patient have contact with soil (e.g. gardening, landscaping, 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)? ☐ Yes ☐ No ☐ Unknown

If Yes, please describe: _____

_____

_____

COMMENTS