State of California—Health and Human Services Agency

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*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐*Years* ☐*Months* ☐*Days*

Address Number & Street - Residence	*Apartment/Unit Number*

City/Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

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*

E-mail Address	*Other Electronic Contact Information*

Work/School Location	*Work/School Contact*

Gender
☐Male ☐Female ☐Other: _____

Pregnant? ☐Yes ☐No ☐Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 5)	*Other Describe/Specify*

Occupation (see list on page 5)	*Other Describe/Specify*

Primary Language
☐English
☐Spanish
☐Other:_____

Ethnicity (check one)
☐Hispanic/Latino
☐Non-Hispanic/Non-Latino
☐Unk

*Race**
(check all that apply, race descriptions on page 5)
☐African-American/Black
☐American Indian or Alaska Native
☐Asian *(check all that apply)*
- ☐Asian Indian ☐Japanese
- ☐Cambodian ☐Korean
- ☐Chinese ☐Laotian
- ☐Filipino ☐Thai
- ☐Hmong ☐Vietnamese
- ☐Other:_____

☐Pacific Islander *(check all that apply)*
- ☐Native Hawaiian ☐Samoan
- ☐Guamanian
- ☐Other:_____

☐White
☐Other:_____
☐Unk

*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: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐Yes ☐No ☐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? ☐Yes ☐No ☐Unk	*Was patient hospitalized?* ☐Yes ☐No ☐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*	*Medical Record 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*	*Medical Record Number*	*Discharge Diagnosis*

OUTCOME

Outcome? ☐Survived ☐Died ☐Unk	*If Survived,* *Survived as of* _____ *(mm/dd/yyyy)*	*Date of Death (mm/dd/yyyy)*

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

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

First three letters of patient's last name: | | | |

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: | | | |

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*

First Reported By
☐Clinician ☐Laboratory ☐Other (specify):_____

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐Yes ☐No ☐Unk	*Contact Name / Case Number*

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

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- 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
- 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