

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

TRICHINOSIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 42

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U
 If yes, symptom onset date (mm/dd/yyyy): ___/___/___

CHECK ALL THAT APPLY: Y N U

Fever Y N U
 Yes, subjective No
 Yes, measured Unknown
 Highest measured temperature _____
 Fever onset date (mm/dd/yyyy): ___/___/___

Fatigue or malaise or weakness Y N U
Sweats (diaphoresis) Y N U
Chills or rigors Y N U
Thirst Y N U
Eyes sensitive to light (photophobia) Y N U
Muscle weakness (paresis) Y N U
Muscle aches / pains (myalgias) Y N U
Swollen eyelids (periorbital edema) Y N U
Hemorrhage-subungual and retinal (trich) Y N U
Cough Y N U
 Onset date (mm/dd/yyyy): ___/___/___
 Productive Y N U

Abdominal pain or cramps Y N U
Diarrhea Y N U
 Describe (select all that apply)
 Bloody Non-bloody
 Watery Other _____
 Maximum number of stools in a 24-hour period: _____

Eosinophilia Y N U

Did the patient have any of the following complications (check all that apply)
 Cardiovascular / cardiac complications (endocarditis, myocarditis, pericarditis, aneurysm, etc.)
 Neurological complications (meningitis, encephalitis, peripheral neuropathy, etc.)
 None of the above

During the 45 days prior to onset of symptoms, did the patient eat any raw or undercooked meat or poultry? Y N U
 Specify meat/poultry: _____
 Specify place of exposure: _____

During the 45 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)? Y N U

Has patient otherwise slaughtered animals or been a butcher, meat cutter, or meat processor? Y N U
 Commercial or non-commercial
 Commercial
 Non-commercial
 Name of commercial establishment _____
 Street address _____
 City _____
 State _____ Zip code _____

Meat from agricultural (domestic/semi-domestic) animals? Y N U
 Specify animal(s):
 Cattle Ratite(s) (ostrich, emu, rhea)
 Goat(s) Sheep
 Horse(s) Swine
 Ranched bison (buffalo) Other
 Ranched deer/Elk Unknown

Meat from wildlife (wild game)? Y N U
 Please specify animal(s):
 Bison (buffalo) Squirrel(s)
 Deer/elk (cervids) Other
 Rabbit(s) Unknown

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? Y N U

REASON FOR TESTING

Why was the patient tested for this condition?
 Symptomatic of disease
 Screening of asymptomatic person with reported risk factor(s)
 Exposed to organism causing this disease (asymptomatic)
 Household / close contact to a person reported with this disease
 Other, specify _____
 Unknown

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U
 Hospital name: _____
 City, State: _____
 Hospital contact name: _____
 Telephone: (____) ____ - _____
 Admit date (mm/dd/yyyy): ___/___/___
 Discharge date (mm/dd/yyyy): ___/___/___

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? Y N
 If yes, specify: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ____/____/____

TRAVEL/IMMIGRATION

The patient is:

Resident of North Carolina

Resident of another state or US territory

None of the above

Did patient have a travel history during the 45 days prior to onset of symptoms? Y N U

Travel dates: From: _____ until _____

To city: _____

To country: _____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

Name: _____

Additional travel/residency information:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 45 days prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U

Name of facility: _____

Dates of contact: _____

During the 45 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? Y N U

If yes, specify: _____

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

FOOD RISK AND EXPOSURE

Where does the patient/patient's family typically buy groceries?

Store name: _____

Store city: _____

Shopping center name/address: _____

CONTINUED

FOOD RISK AND EXPOSURE (continued)

During the 45 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? Y N U

Specify source: _____

Eat any food items that came from a store or vendor where they do not typically shop for groceries? Y N U

Specify source(s): _____

Handle raw meat other than poultry? Y N U

Specify type of meat:

Beef (hamburger/steak, etc)

Pork (ham, bacon, pork chops, sausage, etc)

Lamb/mutton

Wild game, specify: _____

Other, specify: _____

Unknown

Eat ground beef/hamburger? Y N U

Eat other beef/beef products? Y N U

Roast

Steak

Other (specify): _____

Eat pork/pork products? Y N U

Specify type of pork/pork product:

Sausage

Smoked Unsmoked

Chops

Roast

Ham

Smoked Cured Canned

Other, specify: _____

Bacon

BBQ

Other, specify: _____

Eat wild game meat (deer, bear, wild boar)? Y N U

Specify type of wild game meat:

Deer/venison

Bear

Wild boar/javelina/feral hog

Other, specify: _____

Eat other meat / meat products (i.e. ostrich, emu, horse)? Y N U

Specify other meat/meat product:

Ostrich

Emu

Horse

Other, specify: _____

Eat prepackaged, processed meat/meat products (does not include dried, smoked, or preserved products)? Y N U

Specify type of prepackaged, processed meat/meat product:

Hot dogs

Cold Cuts

Bologna

Turkey

Ham

Other cold cut, specify _____

Any other ready-to-eat meat? Specify: _____

Eat ready-to-eat dried, preserved, smoked, or traditionally prepared meat (i.e. summer sausage, salami, jerky)? Y N U

Specify type of prepared meat:

Summer sausage, specify: _____

Salami

Jerky

Other, specify: _____

OUTDOOR EXPOSURE

During the 45 days prior to onset of symptoms, did the patient participate in any outdoor activities? Y N U

If yes, did the patient participate in hunting, trapping, skinning, eviscerating (gutting) animals? Y N U

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U

If yes, specify: _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U

Who was interviewed? _____

Were health care providers consulted? Y N U

Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U

Specify reason if medical records were not reviewed: _____

Notes on medical record verification: _____

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC

City _____

County _____

Outside NC, but within US

City _____

State _____

County _____

Outside US

City _____

Country _____

Unknown

Is the patient part of an outbreak of this disease? Y N

Notes regarding setting of exposure: _____

Trichinosis (*Trichinella spp.*)

1996 CDC Case Definition

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.