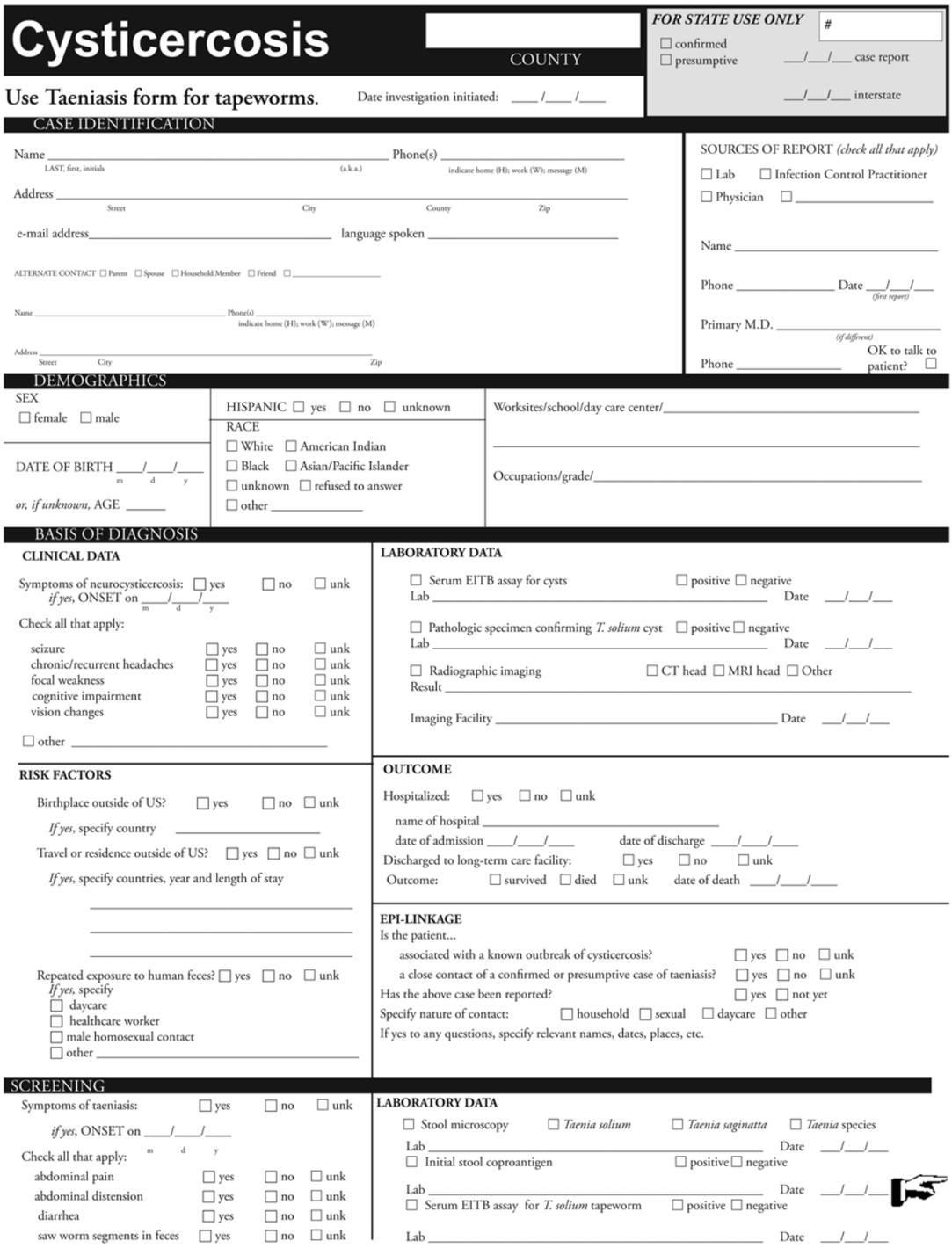
Article DOI: 10.3201/eid1706.101397

Taenia solium infection, Oregon, 2006–2009

Technical Appendix

Interview tool used to gather demographic, clinical, and epidemiologic data from study participants.



Cysticercosis

COUNTY

FOR STATE USE ONLY #

☐ confirmed
☐ presumptive

___/___/___ case report

___/___/___ interstate

Use Taeniasis form for tapeworms. Date investigation initiated: ____ /____ /____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City County Zip

e-mail address _____ language spoken _____

ALTERNATE CONTACT ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT *(check all that apply)*
☐ Lab ☐ Infection Control Practitioner
☐ Physician ☐ _____

Name _____

Phone _____ Date ___/___/___ *(first report)*

Primary M.D. _____ *(if different)*

Phone _____ OK to talk to patient? ☐

DEMOGRAPHICS

SEX
☐ female ☐ male

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____

HISPANIC ☐ yes ☐ no ☐ unknown

RACE
☐ White ☐ American Indian
☐ Black ☐ Asian/Pacific Islander
☐ unknown ☐ refused to answer
☐ other _____

Worksites/school/day care center/_____

Occupations/grade/_____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptoms of neurocysticercosis: ☐ yes ☐ no ☐ unk
if yes, ONSET on ____/____/____ m d y

Check all that apply:

seizure	☐ yes	☐ no	☐ unk
chronic/recurrent headaches	☐ yes	☐ no	☐ unk
focal weakness	☐ yes	☐ no	☐ unk
cognitive impairment	☐ yes	☐ no	☐ unk
vision changes	☐ yes	☐ no	☐ unk

☐ other _____

LABORATORY DATA

☐ Serum EITB assay for cysts ☐ positive ☐ negative
Lab _____ Date ___/___/___

☐ Pathologic specimen confirming *T. solium* cyst ☐ positive ☐ negative
Lab _____ Date ___/___/___

☐ Radiographic imaging ☐ CT head ☐ MRI head ☐ Other
Result _____

Imaging Facility _____ Date ___/___/___

RISK FACTORS

Birthplace outside of US? ☐ yes ☐ no ☐ unk
If yes, specify country _____

Travel or residence outside of US? ☐ yes ☐ no ☐ unk
If yes, specify countries, year and length of stay
_____
_____
_____

Repeated exposure to human feces? ☐ yes ☐ no ☐ unk
If yes, specify
☐ daycare
☐ healthcare worker
☐ male homosexual contact
☐ other _____

OUTCOME

Hospitalized: ☐ yes ☐ no ☐ unk
name of hospital _____
date of admission ____/____/____ date of discharge ____/____/____
Discharged to long-term care facility: ☐ yes ☐ no ☐ unk
Outcome: ☐ survived ☐ died ☐ unk date of death ____/____/____

EPI-LINKAGE

Is the patient...
associated with a known outbreak of cysticercosis? ☐ yes ☐ no ☐ unk
a close contact of a confirmed or presumptive case of taeniasis? ☐ yes ☐ no ☐ unk
Has the above case been reported? ☐ yes ☐ not yet
Specify nature of contact: ☐ household ☐ sexual ☐ daycare ☐ other
If yes to any questions, specify relevant names, dates, places, etc.

SCREENING

Symptoms of taeniasis: ☐ yes ☐ no ☐ unk
if yes, ONSET on ____/____/____ m d y

Check all that apply:

abdominal pain	☐ yes	☐ no	☐ unk
abdominal distension	☐ yes	☐ no	☐ unk
diarrhea	☐ yes	☐ no	☐ unk
saw worm segments in feces	☐ yes	☐ no	☐ unk

LABORATORY DATA

☐ Stool microscopy ☐ *Taenia solium* ☐ *Taenia saginatta* ☐ *Taenia* species
Lab _____ Date ___/___/___
☐ Initial stool coproantigen ☐ positive ☐ negative

Lab _____ Date ___/___/___
☐ Serum EITB assay for *T. solium* tapeworm ☐ positive ☐ negative

Lab _____ Date ___/___/___

PATIENT'S NAME

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

Name _____ Age _____ Relation to Case _____ By proxy ☐ yes ☐ no Proxy name _____

NEUROCYSTICERCOSIS SCREENING

if yes to any recommend medical evaluation of neurocysticercosis.

	yes	no	unk	date
seizure	☐	☐	☐	___/___/___
cognitive impairment	☐	☐	☐	___/___/___
chronic/recurrent headaches	☐	☐	☐	___/___/___
focal weakness	☐	☐	☐	___/___/___
vision changes	☐	☐	☐	___/___/___
unexplained neuro deficit	☐	☐	☐	___/___/___

TAENISIS SCREENING

Saw worm segments in feces ☐ yes ☐ no ___/___/___

Stool microscopy ☐ *Taenia solium* ☐ *Taenia saginatta* ☐ *Taenia* species
Lab _____ Date ___/___/___

Initial stool coproantigen ☐ positive ☐ negative
Lab _____ Date ___/___/___

Serum EITB assay for *T. solium* tapeworm ☐ positive ☐ negative
Lab _____ Date ___/___/___

Comments

Stool Sample Collected ☐ yes ☐ no ☐ unk
Medical Evaluation ☐ yes ☐ no ☐ unk
Education Provided ☐ yes ☐ no ☐ unk

Name _____ Age _____ Relation to Case _____ By proxy ☐ yes ☐ no Proxy name _____

NEUROCYSTICERCOSIS SCREENING

if yes to any recommend medical evaluation of neurocysticercosis.

	yes	no	unk	date
seizure	☐	☐	☐	___/___/___
cognitive impairment	☐	☐	☐	___/___/___
chronic/recurrent headaches	☐	☐	☐	___/___/___
focal weakness	☐	☐	☐	___/___/___
vision changes	☐	☐	☐	___/___/___
unexplained neuro deficit	☐	☐	☐	___/___/___

TAENISIS SCREENING

Saw worm segments in feces ☐ yes ☐ no ___/___/___

Stool microscopy ☐ *Taenia solium* ☐ *Taenia saginatta* ☐ *Taenia* species
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Lab _____ Date ___/___/___

Comments:

Stool Sample Collected ☐ yes ☐ no ☐ unk
Medical Evaluation ☐ yes ☐ no ☐ unk
Education Provided ☐ yes ☐ no ☐ unk

Name _____ Age _____ Relation to Case _____ By proxy ☐ yes ☐ no Proxy name _____

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	yes	no	unk	date
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cognitive impairment	☐	☐	☐	___/___/___
chronic/recurrent headaches	☐	☐	☐	___/___/___
focal weakness	☐	☐	☐	___/___/___
vision changes	☐	☐	☐	___/___/___
unexplained neuro deficit	☐	☐	☐	___/___/___

TAENISIS SCREENING

Saw worm segments in feces ☐ yes ☐ no ___/___/___

Stool microscopy ☐ *Taenia solium* ☐ *Taenia saginatta* ☐ *Taenia* species
Lab _____ Date ___/___/___

Initial stool coproantigen ☐ positive ☐ negative
Lab _____ Date ___/___/___

Serum EITB assay for *T. solium* tapeworm ☐ positive ☐ negative
Lab _____ Date ___/___/___

Comments:

Stool Sample Collected ☐ yes ☐ no ☐ unk
Medical Evaluation ☐ yes ☐ no ☐ unk
Education Provided ☐ yes ☐ no ☐ unk

ADMINISTRATION

Cysticercosis / January 2009

Remember to copy patient's name to the top of this page.

Initial report sent to OHS on ___/___/___

Completed by _____ Date _____ Phone _____

Case investigation sent to OHS on ___/___/___