TEXAS Health and Human Services | 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

Fascioliasis Investigation Form

NBS Patient ID:

Patient's name: _____
Last First MI

Address: _____

City: _____ **County:** _____ **Zip:**_____

Phone 1: ( ) _____ **Phone 2:** ( ) _____

Date of birth: ____/____/____ **Age:** ____**Sex:** ☐Male ☐Female ☐Unk

Race: ☐White ☐Black ☐Asian ☐Pacific Islander

☐Native American/Alaskan ☐Unknown ☐ Other: _____

Hispanic: ☐ Yes ☐ No ☐ Unknown

Patient Occupation:_____

Parent/guardian's name_____

Country of origin:_____ **Date of arrival in US:** ___/___/___

Reported by: _____

Agency: _____

Phone: (**)**_____**Date reported:** ____/____/____

Investigated by: _____

Agency: _____

Phone: (**)** _____

Email:_____

Investigation start date: ____/____/____

Investigation completed date: ____/____/____

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):

☐ Fever Max Temp:_____ ☐ Malaise ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Diarrhea

☐ Hepatomegaly (swollen liver) ☐ Abnormal Liver Function tests ☐ Shortness of breath ☐ Skin rash

☐ Jaundice ☐ Biliary colic

☐ Other: _____

Complications: ☐ Biliary obstruction ☐ Inflammation of liver ☐ Inflammation of gallbladder ☐ Inflammation of pancreas

☐ 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: ____/____/_____

DIAGNOSIS/TREATMENT

Date of diagnosis: ____/____/_____

Did the patient receive treatment? ☐ Yes ☐ No ☐ Unk Treatment start date: ___/___/___

If yes: ☐ Triclabendazole ☐ Other _____

LABORATORY

☐ Microscopic identification of eggs from ☐ Stool ☐ Duodenal contents ☐ Bile ☐ Other:_____

Collection date: _____/_____/_____

Results: ☐ Eggs detected: ☐ *F. hepatica* ☐ *F. gigantica*

☐ No eggs detected ☐ Unknown

☐ Serology: Collection date: _____/_____/_____

☐ EIA- Antigen Results: ☐ Ag detected ☐ Negative ☐ Indeterminate

☐ Immunoblot Results: ☐ Positive ☐ Negative

☐ EIA- Antibody Results: IgM: ☐ Pos ☐ Neg ☐ Indeterminate IgG: ☐ Pos ☐ Neg ☐ Indeterminate

Fascioliasis Investigation Form Continued	**NBS Patient ID:**

EXPOSURE HISTORY

Travel History:

Has the patient lived in a different location or traveled in the last 2 years? ☐ Yes ☐ No ☐ Unknown If yes, where and when?

Where (Country or US City and State)	**Dates**	**Traveler**
		☐ Traveled ☐ Lived
		☐ Traveled ☐ Lived
		☐ Traveled ☐ Lived
		☐ Traveled ☐ Lived
		☐ Traveled ☐ Lived

Water Exposure:

Main source of drinking water:_____

Did the case have exposure to any recreational water sources? ☐ Yes ☐ No

If yes, please specify: ☐ River ☐ Pond ☐ Ocean ☐ Stream ☐ Lake ☐ Other:_____

Name(s) of body of water, date(s), location(s): _____

_____

Food History:

Did the case **eat any Raw Watercress?** ☐ Yes ☐ No ☐ Unsure

If yes, Where, When,: _____

Did the case **eat any other water plants?** ☐ Yes ☐ No ☐ Unsure

If yes, Where, When,: _____

COMMENTS