**CASE IDENTIFICATION**

**CLINICAL DATA**

Symptoms of taeniasis:
- [ ] yes
- [ ] no
- [ ] unk
  - if yes, ONSET on ___/___/___

Check all that apply:
- [ ] abdominal pain
- [ ] abdominal distension
- [ ] diarrhea
- [ ] saw worm segments in feces

Symptoms of cysticercosis:
- [ ] yes
- [ ] no
- [ ] unk
  - if yes, ONSET on ___/___/___

Check all that apply:
- [ ] seizure
- [ ] chronic/recurrent headaches
- [ ] acute headache
- [ ] nausea/vomiting
- [ ] focal weakness
- [ ] cognitive impairment
- [ ] psychosis
- [ ] loss of consciousness
- [ ] paresthesias
- [ ] vision changes
- [ ] subcutaneous nodules

**LABORATORY DATA**

- [ ] Fecal culture confirming Taenia solium?
  - Lab ___________________________ Date ___/___/___
- [ ] Fecal culture confirming Taenia species?
  - Lab ___________________________ Date ___/___/___
- [ ] Coproantigen test positive?
  - Lab ___________________________ Date ___/___/___
- [ ] Serum EITB assay positive?
  - Lab ___________________________ Date ___/___/___
- [ ] Serum ELISA positive?
  - Lab ___________________________ Date ___/___/___
- [ ] CT scan? CT results:
  - [ ] confirmatory
  - [ ] compatible
  - [ ] suggestive
  - Facility where scan was performed __________________________ Date ___/___/___
- [ ] MRI scan? MRI results:
  - [ ] confirmatory
  - [ ] compatible
  - [ ] suggestive
  - Facility where scan was performed __________________________ Date ___/___/___
- [ ] Pathologic specimen confirming T. solium cyst?
  - Lab ___________________________ Date ___/___/___

**SOURCES OF REPORT (check all that apply)**

- [ ] Lab
- [ ] Infection Control Practitioner
- [ ] Physician
- [ ] Other

**LABORATORY DATA**

- [ ] Fecal culture confirming Taenia solium?
  - Lab ___________________________ Date ___/___/___
- [ ] Fecal culture confirming Taenia species?
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  - [ ] compatible
  - [ ] suggestive
  - Facility where scan was performed __________________________ Date ___/___/___
- [ ] Pathologic specimen confirming T. solium cyst?
  - Lab ___________________________ Date ___/___/___
**Basis of Diagnosis**

**Risk Factors for Disease**

- Frequent or extended travel outside of US? □ yes □ no □ unk
  - If yes, specify countries ________________________________
  - ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________

- Residence outside of US? □ yes □ no □ unk
  - If yes, specify countries ________________________________
  - ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________

- Household contact with travel or residence outside of US? □ yes □ no □ unk
  - If yes, specify countries ________________________________
  - ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________

- Household contact with history of tapeworm, cysticercosis, seizures, chronic headaches, other unexplained neurologic disease? □ yes □ no □ unk
  - Name(s) of household contacts above ________________________________
  - Relationship ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________
  - ____________________________________________________

**Diagnostic Criteria Checklist (Cysticercosis)**

**Absolute Criteria**
1. Biopsy or autopsy demonstrating parasite in tissue □ yes □ no □ unk
2. Cystic lesions showing the scolex on CT or MRI □ yes □ no □ unk
3. Direct visualization of parasites in retina □ yes □ no □ unk

**Major Criteria**
1. CT or MRI scan with highly suggestive lesions □ yes □ no □ unk
2. Positive EITB assay □ yes □ no □ unk
3. Resolution of lesions after treatment with praziquantel or albendazole □ yes □ no □ unk
4. Spontaneous resolution of small enhancing lesions seen on CT or MRI □ yes □ no □ unk

**Minor Criteria**
1. CT or MRI with compatible lesions □ yes □ no □ unk
2. Symptoms compatible with cysticercosis □ yes □ no □ unk
3. Positive CSF ELISA □ yes □ no □ unk
4. Subcutaneous nodules □ yes □ no □ unk

**Epidemiologic Criteria**
1. Household contact with evidence of T. solium infection □ yes □ no □ unk
2. Residence in endemic area □ yes □ no □ unk
3. Frequent or extended travel to endemic area □ yes □ no □ unk

**Infection Timeline**

Exposure period to date of onset usually <5 years, sometimes >25 years.

**Case-Contact Management and Follow-Up**

**Household Roster/Other Contacts**

- Tapeworm carriers identified □ yes □ no □ unk

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<th>Age</th>
<th>Relation to Case</th>
<th>Date of test</th>
<th>Date treated</th>
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**Administration**

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

Completed by ______________________________ Date __________________ Phone ________________ Case investigation sent to OHS on ___/___/___

Initial report sent to OHS on ___/___/___

Taeniasis/Cysticercosis / February 2004