



NEW WORLD SCREWORM (NWS) CASE REPORT

Department of Health and Human Services, Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA, 30329

Contact newworldscrewworm@cdc.gov for submission instructions to CDC.



Required fields indicated by an asterisk (*)

1. *Case ID (Local Record ID): _____ 2. *Person ID (Local Subject ID): _____ 3. *National reporting jurisdiction: _____
4. *Case Classification: Confirmed Probable Suspect Not a Case
5. Earliest date of report to a public health agency (mm/dd/yyyy): _____
6. Earliest specimen collection date associated with a positive laboratory result (mm/dd/yyyy): _____
7. Earliest result date of a positive laboratory result (mm/dd/yyyy): _____

CASE DEMOGRAPHIC INFORMATION

8. a) Age: _____ b) Age units: yrs. mos. wks. days 9. Date of Birth (mm/dd/yyyy): _____
10. Sex: Male Female Unknown
11. Race (select all that apply): American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Asian Black or African American White Unknown Other, specify: _____ Refused to answer
12. Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
13. Country of residence: _____ 15. U.S. county of residence: _____
14. U.S. state of residence: _____ 16. Zip code: _____

CASE HISTORY

17. Is the person currently employed? Yes No Unknown
- a) If yes, what kind of work does the person do? (list all reported): _____
- b) If yes, what kind of business or industry does the person work in? (list all reported): _____
18. Does the person have any of the following type(s) of disabilities:
- | | Yes | No | Unknown | | Yes | No | Unknown |
|---|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| a) Vision (blindness, serious difficulty seeing even when wearing glasses) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e) Difficulty performing personal care activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Hearing (serious difficulty hearing or deafness) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | f) Impaired mobility (serious difficulty walking or climbing stairs) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Communication (difficulty understanding others or being understood in your usual language) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | g) Impaired cognition (serious difficulty such as concentrating, remembering, or making decisions due to a physical, mental, or emotional condition) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Functionally dependent (e.g., difficulty doing errands alone) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | h) Intellectual disability (intellectual developmental disorder) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
19. At the time of the diagnosis, was the person immunocompromised? Yes No Unknown
- a) If yes, specify the condition(s): _____
20. Did the person have recent history (e.g., in the two weeks prior to symptom onset) of unhealed wounds, open sores, or were they recovering from surgery? Yes No Unknown

FORM CONTINUES ON NEXT PAGE

NEW WORLD SCREWORM (NWS) CASE REPORT

CLINICAL INFORMATION

21. Did the person have any signs or symptoms consistent with an infestation? Yes No Unknown

a) If yes, earliest date of onset of signs or symptoms (*mm/dd/yyyy*): _____

22. Did the person have any of the following signs or symptoms?

	Yes	No	Unknown		Yes	No	Unknown
a) Skin lesion, wound, or sore that worsened over time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f) Sensation of movement at or near the site of infestation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g) Visible larvae or maggots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h) Nosebleed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Discharge or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i) Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Foul odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If other, specify: _____			

23. Was the person's infestation in (*select all that apply*): Wound Body orifice (mucous membrane) Surgical site

24. Where on the person's body was the infestation? _____

25. What was the earliest date that the infestation was identified by a clinician as the final, suspected or most likely diagnosis? (*mm/dd/yyyy*): _____

26. Was the infestation treated by removal of larvae from the infestation? Yes No Unknown

If yes, enter information for each time the person received treatment for the infestation.

Date of Treatment (<i>mm/dd/yyyy</i>)	Location of treatment (e.g., urgent care, physician office)	How many larvae were removed?	How were removed larvae disposed?	List any other treatment(s) received
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

27. Were there any larvae that fell out of or were removed from the person's infestation that were not collected by a healthcare provider?
 Yes No Unknown

28. Was the person admitted to the hospital for this illness? Yes No Unknown

If the person was admitted to the hospital for this illness more than once, enter information for the first hospitalization.

a) If yes, date of hospital admission (*mm/dd/yyyy*): _____

c) Days hospitalized for this illness: _____

b) If yes, date of hospital discharge (*mm/dd/yyyy*): _____

29. Is the person deceased? Yes No Unknown

a) If yes, date of death (*mm/dd/yyyy*): _____

b) If yes, is the person's death associated with NWS infestation? Yes No Unknown

FORM CONTINUES ON NEXT PAGE

NEW WORLD SCREWORM (NWS) CASE REPORT

EPIDEMIOLOGIC INFORMATION

30. In the 10 days **before** symptom onset, where did the person reside (spend at least one night)? *(select all that apply):*

Note: Congregate living settings are facilities (not private residences) where people who are not related reside in close proximity and share at least one common room, such as a sleeping room, kitchen, bathroom, or living room.

- | | | |
|---|---|--|
| <input type="checkbox"/> Private residence in a long-term arrangement (i.e., more than two weeks) | <input type="checkbox"/> Hotel/motel or vacation rental in a long-term arrangement (i.e., more than two weeks) | <input type="checkbox"/> Private residence in a short-term arrangement (i.e., two weeks or less) |
| <input type="checkbox"/> Hotel/motel or vacation rental in a short-term arrangement (i.e., two weeks or less) | <input type="checkbox"/> Shelter or safe haven (congregate setting) | <input type="checkbox"/> Temporary, non-congregate housing provided by charity or government program (e.g., transitional housing, hotel/motel) |
| <input type="checkbox"/> Structure or vehicle not meant for human habitation | <input type="checkbox"/> Vehicle meant for human habitation (e.g., RV) | <input type="checkbox"/> Outside or open air (e.g., tent, bus shelter), part of an established encampment |
| <input type="checkbox"/> Outside or open air (e.g., tent, bus shelter), not part of an established encampment | <input type="checkbox"/> Agricultural (e.g., livestock, farm) worker housing, including migrant worker housing | <input type="checkbox"/> Military congregate housing (e.g., barracks) |
| <input type="checkbox"/> Other congregate housing for workers | <input type="checkbox"/> School/university congregate housing (e.g., dormitories) | <input type="checkbox"/> Federal adult correctional facility |
| <input type="checkbox"/> State adult correctional facility | <input type="checkbox"/> Local adult jail/detention facility | <input type="checkbox"/> Juvenile correctional/detention facility |
| <input type="checkbox"/> Other correctional/detention facility (e.g., border detention facility) | <input type="checkbox"/> Mental/Behavioral/Substance use treatment facility | <input type="checkbox"/> Long term care facility (e.g., skilled nursing facility, nursing home, assisted living) |
| <input type="checkbox"/> Other inpatient medical facility | <input type="checkbox"/> Group home or residential facility not provided by employer or school (e.g., recovery house) | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other, specify living situation(s): | | <input type="checkbox"/> Declined to respond |

Travel

During the 10 days **before** symptom onset:

31. Did the person spend time outside the United States? Yes No Unknown

32. Did the person spend time within the United States, but outside their county of residence?* Yes No Unknown

**For a person with no current county of residence in the United States, select the appropriate response for time spent within the United States during the 10 days before symptom onset.*

33. If the person reported travel, enter each travel destination:

Instructions for entering travel information:

- If the person traveled to the same destination on more than one consecutive day, (e.g., traveled to the same county every day), enter this as one destination; enter the earliest date of arrival as the Date of Arrival and the most recent date of departure as the Date of Departure.*
- For a person with no current county of residence in the United States, include all locations visited in the United States during the 10 days before symptom onset.*

International country of recent travel	U.S. state of recent travel	U.S. county of recent travel	Date of Arrival (mm/dd/yyyy)	Date of Departure (mm/dd/yyyy)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FORM CONTINUES ON NEXT PAGE

NEW WORLD SCREWORM (NWS) CASE REPORT

EPIDEMIOLOGIC INFORMATION, continued

Exposures

34. During the 10 days **before** symptom onset, was the person exposed to any of the following:

Include the following information in the **Details** field for each exposure:

- **Animals or locations with animals:** type of animal(s) and if the animal(s) showed evidence of an infestation (e.g. head shaking, irritated behavior, smell of decay, presence of fly larvae/maggots in wounds)
- **A person with an infestation:** details on contact type (e.g., travel companion, coworker, household member) and case identifier number, if available.

Instructions for entering exposure information:

- *If the exposure started prior to the 10 days before symptom onset, enter the known or estimated start date if available. If not available, enter the date 10 days before the date of symptom onset as the Exposure Start Date.*
- *If the same exposure occurred on more than one consecutive day, (e.g., exposure to the same domestic animal every day), enter this as one exposure; enter the earliest exposure date as the Exposure Start Date and the most recent exposure date as the Exposure End Date.*

Exposure	Yes	No	Unknown	Exposure Start Date (mm/dd/yyyy)	Exposure End Date (mm/dd/yyyy)	Details
Animals						
a) Livestock (e.g., cattle, goats, sheep, pigs, horses, or poultry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
b) Domestic animals not considered livestock (e.g., dogs, cats, companion animals, pets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
c) Wildlife (e.g., deer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Locations with Animals						
d) Farm or ranch with animals (e.g. visiting, working, or living)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
e) Fair or event with animals (e.g., visiting or working)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
f) Zoo, including petting zoo (e.g., visiting or working)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
g) Animal shelter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
h) Hunting location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
i) A person with a NWS infestation or similar infestation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other exposures						
Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

FORM CONTINUES ON NEXT PAGE

NEW WORLD SCREWORM (NWS) CASE REPORT

LABORATORY TESTING

Enter laboratory testing conducted for NWS identification. Include confirmatory laboratory testing for NWS (i.e., laboratory testing conducted by CDC DPDx, USDA NVSL, or other laboratory with training to identify NWS larvae).

35. Test 1

- a) Date of specimen collection (*mm/dd/yyyy*): _____ b) Date of result (*mm/dd/yyyy*): _____
- c) Specimen type (*select all that apply*): Whole Organism Image or Video Other, specify: _____
- d) Select the laboratory that conducted the testing: CDC DPDx USDA NVSL Public health laboratory Clinical laboratory
 Commercial reference laboratory (e.g., ARUP, Quest) Other laboratory, specify: _____
- e) Test Type: Ova/parasite examination (parasite morphological identification) Other, specify _____
- f) Test Result: *Cochliomyia hominivorax* Fly larva Arthropod Unable to identify No parasite found
 Other, specify: _____
- g) What stage(s) of larvae were identified? (*select all that apply*): 1st instar 2nd instar 3rd instar Unknown Not reported

36. Test 2

- a) Date of specimen collection (*mm/dd/yyyy*): _____ b) Date of result (*mm/dd/yyyy*): _____
- c) Specimen type (*select all that apply*): Whole Organism Image or Video Other, specify: _____
- d) Select the laboratory that conducted the testing: CDC DPDx USDA NVSL Public health laboratory Clinical laboratory
 Commercial reference laboratory (e.g., ARUP, Quest) Other laboratory, specify: _____
- e) Test Type: Ova parasite examination (parasite morphological identification) Other, specify _____
- f) Test Result: *Cochliomyia hominivorax* Fly larva Arthropod Unable to identify No parasite found
 Other, specify: _____
- g) What stage(s) of larvae were identified? (*select all that apply*): 1st instar 2nd instar 3rd instar Unknown Not reported

37. Test 3

- a) Date of specimen collection (*mm/dd/yyyy*): _____ b) Date of result (*mm/dd/yyyy*): _____
- c) Specimen type (*select all that apply*): Whole Organism Image or Video Other, specify: _____
- d) Select the laboratory that conducted the testing: CDC DPDx USDA NVSL Public health laboratory Clinical laboratory
 Commercial reference laboratory (e.g., ARUP, Quest) Other laboratory, specify: _____
- e) Test Type: Ova/parasite examination (parasite morphological identification) Other, specify _____
- f) Test Result: *Cochliomyia hominivorax* Fly larva Arthropod Unable to identify No parasite found
 Other, specify: _____
- g) What stage(s) of larvae were identified? (*select all that apply*): 1st instar 2nd instar 3rd instar Unknown Not reported

Comments:

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