



CHRONIC STRONGYLOIDIASIS CLINICAL AUDIT

GP Identifier	Patient Number	Year of Birth
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Consent Given	<input type="checkbox"/> Yes <input type="checkbox"/> No

INDICATIONS FOR TESTING (tick relevant boxes and add comments)

Demographics: (At risk groups)	
<input type="checkbox"/> Indigenous <input type="checkbox"/> Immigrant <input type="checkbox"/> Traveller <input type="checkbox"/> Military service <input type="checkbox"/> Sanitation worker <input type="checkbox"/> Other ____	
Exposure:	
<input type="checkbox"/> Endemic area, specify country _____ If Australia, specify region _____	Estimated time since exposure _____
<input type="checkbox"/> Household contact	<input type="checkbox"/> Past <input type="checkbox"/> Current / Ongoing
Relevant Clinical History:	
<input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin <input type="checkbox"/> Renal <input type="checkbox"/> Systemic (CNS, cardiac, non-specific) <input type="checkbox"/> Other <input type="checkbox"/> Comments _____	<input type="checkbox"/> Septic events <input type="checkbox"/> Hospital admissions <input type="checkbox"/> Malnourished <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Chronic disease <input type="checkbox"/> Eosinophilia <input type="checkbox"/> Past history of positive strongyloidiasis <input type="checkbox"/> Requires immunosuppressants or steroids

PAST RESULTS (history of relevant results and treatment):

DATE	HB	ESR	EOSIN. COUNT	%EOS	STRONGY SERO RESULT	STOOL SPECIMEN	DRUG	DOSE	DURATION	DIRECTLY OBSERVED YES / NO	COMMENTS / FOLLOW-UP

CURRENT RESULTS:

DATE	HB	ESR	EOSIN. COUNT	%EOS	STRONGY SERO RESULT	STOOL SPECIMEN	DRUG	DOSE	DURATION	DIRECTLY OBSERVED YES / NO	COMMENTS / FOLLOW-UP

COMMENTS:
