

Chagas Disease Case Investigation Form

Texas Case Number:

Condition (circle one): Chagas, Acute Chagas, Chronic Symptomatic Chagas, Chronic Indeterminate Classification: Suspect Probable Confirmed Not a Case

P A	Last Name F	rst Name MI Patient's Phone Number					
T	Street Address	City County Zipcode					
E N	Place of Birth (Patient):	Place of Birth (Mother):					
Т	Age: Date of Birth:	Sex: M F					
	Race: White Black Asian Native American Other	Hispanic: Yes No Unknown					
	Is patient symptomatic: YES NO If Yes, Date of Onset: Onset of illness was (Circle one) Abrupt Gradual						
С	Was patient hospitalized? YES NO If YES, which hospital?						
0	Date of admission: Date of discharge: Discharge diagnosis:						
R S	Did Patient die: YES NO If Yes, Date of death:						
Е	Attending Physician:	_()					
	(Name)	(Phone) (FAX)					
	Physician's Address: City, State, Zipcode						
	Circle All That Apply	Circle All That Apply					
	Fever Max temp:° F Duration (days):	Chagoma Date of Onset					
M E	Malaise Nausea/vomiting Diarrhea	Location:					
D I	Dizziness Lymphadenopathy Chest Pain	Hepatosplenomegaly Megacolon Megaesophagus					
С	Cardiac Arrhythmias Palpitations Myocarditis	Other Symptoms or Clinical Signs (Describe):					
A L	Presyncope Syncope Dilated Cardiomyopa	пу					
	Difficulty Breathing Difficulty Swallowing						
	Edema of Feet/Ankles Romaña's Sign						
	Please Circle Correct Response	Please Circle Correct Response					
	Triatomids present at patient's residence? YES NO UNKNOW	N Has patient ever had a blood transfusion? YES NO UNKNOWN					
	History of contact with triatomids? YES NO UNKNOW	N If Yes, indicate date and location in Comments section on reverse.					
	Rodents present in patient's environment? YES NO UNKNOV	N Is patient a blood donor? YES NO UNKNOWN					
O T	Wild animals present in patient's environment? YES NO UNKNOV	If Yes, indicate date and location in Comments section on reverse.					
H	If Yes, what kind:	Is patient pregnant? YES NO UNKNOWN					
E R	Are dogs present at patient's residence? YES NO UNKNOW	If Yes, indicate number of weeks and due date in Comments section on reverse.					
Е	If Yes, have any died of Chagas disease or of unknown causes?	Is patient breastfeeding or planning to breastfeed?					
P	YES NO UNKNO	YES NO UNKNOWN					
D E	If Yes, describe circumstances in Comments section on reverse.						
M I	Has the patient ever lived outside of the United States for longer than 30 days? YES NO UNKNOWN If YES, give pertinent details						
O L	Country City/State Ho	V Long From (mo/yr) To (mo/yr) Rural (Circle)					
O G	If symptomatic, did the patient travel outside his/her county of residence in the 60 days prior to onset? YES NO UNKNOWN						
Υ	If YES, give travel history (when, where, how long):						
	Country City/State Ho	V Long From (date) To (date) Rural (Circle) Yes No Unk					
		Tes INC Offic					
	Transmission thought to be (Circle One): Zoonotic/Local Zoonotic/Imported Transfusion/Transplant Transplacental						
	- 1 anomiosion arough to 50 (onoio ono) 20010ao 200ai - 20	Transferior Transferior Transplant Transplatorital					

DSHS Form # EF15-14070 Revised: Apr 2013

Patient's Name:				
-----------------	--	--	--	--

	Specimen Date	Specimen Type (Circle and/or Describe)	Method	Results: (Circle)	Laboratory Name	Remarks		
		Blood/Buffy Coat	Wet mount					
		Blood/Buffy Coat	Thick or Thin Blood Smear	POS NEG NE)			
L		Serum	ELISA	POS NEG NE				
A B		Serum	IFA (Titer)	POS NEG NE)			
O R		Blood/Tissue	PCR	POS NEG NE				
Α		Serum	RIPA	POS NEG NE				
O		Serum	TESA Immunoblot	POS NEG NE	CDC			
R Y		Blood/Tissue	Culture	Isolate:	CDC			
					Y			
D A T	Were triatom	NO						
Α	If YES, Date	e:	Collection Location: _		Host:			
	Species:		Number Submitted: _		PCR Positive	Negative		
	Species:		Number Submitted: _		PCR Positive	Negative		
T R	Was the patient treated? YES NO UNK							
E	Nifurtimox	YES NO UNK	Dosage:		Started:			
A T	Benznidazol	e YES NO UNK	Dosage:	Date	Started:	Ended:		
M E	Other		_ Dosage:	Date	Started:	Ended:		
N T	Other		_ Dosage:	Date	Started:	Ended:		
OTHER INFORMATION AND COMMENTS								
Investigation Start Date: Date First Reported: Reporting Facility: Investigated by: Phone: ()								
E-Ma	ail:				Date Completed:			

DSHS Form # EF15-14070 Revised: Apr 2013