For Use by DSHS Central Office Only

Approved By: _____ **Date:** _____

MMWR Year: _____

TEXAS Health and Human Services | Texas Department of State Health Services

☐ Acute
☐ Chronic Indeterminate
☐ Chronic Symptomatic

Chagas Disease Case Investigation Form

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

☐ Confirmed ☐ Probable ☐ Suspect

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female ☐ Unknown

Place of Birth (Patient): _____ Place of Birth (Mother): _____

Street Address: _____ City, State, Zip: _____

Patient Phone: _____ County of Residence: _____

Race: ☐ Asian ☐ American Indian/Alaskan Native
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Clinical Information

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown **If yes,** Date of illness onset: ____/____/_____

If yes, was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, provide name and location of hospital: _____

Dates of hospitalization: Admission ____/____/_____ Discharge ____/____/_____

Physician: _____ Address: _____

City, State, Zip: _____ Phone: _____ Fax: _____

Was the patient pregnant during illness (or prior to sample collection for asymptomatic patients)?

☐ Yes ☐ No ☐ Unknown ☐ N/A

If yes, provide week of pregnancy at onset: _____ Outcome of pregnancy? _____

Is the patient deceased? ☐ Yes ☐ No ☐ Unknown

If yes, provide date of death: ____/____/_____ *(submit documentation)*

Clinical Evidence

For SYMPTOMATIC cases, complete appropriate section below
For CHRONIC INDETERMINATE cases, skip this section and proceed to Laboratory Findings

Acute cases ONLY

Fever	☐ Yes	☐ No	☐ Unknown
Malaise	☐ Yes	☐ No	☐ Unknown
Nausea/vomiting	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown
Lymphadenopathy	☐ Yes	☐ No	☐ Unknown
Acute myocarditis	☐ Yes	☐ No	☐ Unknown
Romaña's Sign	☐ Yes	☐ No	☐ Unknown
Chagoma	☐ Yes	☐ No	☐ Unknown

If yes, onset: ____/____/_____

If yes, location: _____

Hepatosplenomegaly	☐ Yes	☐ No	☐ Unknown

Chronic Symptomatic cases ONLY

Dizziness	☐ Yes	☐ No	☐ Unknown
Chest pain	☐ Yes	☐ No	☐ Unknown
Cardiac arrhythmias	☐ Yes	☐ No	☐ Unknown
Palpitations	☐ Yes	☐ No	☐ Unknown
Syncope	☐ Yes	☐ No	☐ Unknown
Dilated cardiomyopathy	☐ Yes	☐ No	☐ Unknown
Difficulty breathing	☐ Yes	☐ No	☐ Unknown
Difficulty swallowing	☐ Yes	☐ No	☐ Unknown
Megacolon	☐ Yes	☐ No	☐ Unknown
Megaesophagus	☐ Yes	☐ No	☐ Unknown

NBS Patient ID: _____ Patient Name: _____

Laboratory Findings				
Test	**Date Collected**	**Titer/ Value**	**Interpretation**	**Lab Name**
Blood donor screening test (such as RIPA or ESA)		N/A		
Examination of blood smear		N/A		
Trypanosoma cruzi PCR		N/A	☐ Detected ☐ Not detected	CDC
T. cruzi IgM IFA			☐ Positive ☐ Negative	
T. cruzi IgG ELISA			☐ Positive ☐ Negative	
T. cruzi AB EIA (only at CDC)			☐ Reactive ☐ Non-reactive ☐ Indeterminate	CDC
T. cruzi AB IB (TESA)		N/A	☐ Positive ☐ Negative	CDC
Other test (describe):				

Were triatomines submitted to the Texas Department of State Health Services for identification and testing at CDC? ☐ Yes ☐ No ☐ Unknown

If yes: What was the *T. cruzi* PCR result for the triatomine(s)? ☐ Positive ☐ Negative

Provide specimen ID number(s): _____

Epidemiology: Part A
For ACUTE Chagas Disease cases, complete this section
For CHRONIC SYMPTOMATIC OR INDETERMINATE Chagas Disease cases, please proceed to PART B

Part A: ACUTE Chagas Disease cases

During the **4 months** prior to illness onset (or prior to sample collection for asymptomatic patients):

Did the patient donate or receive a blood transfusion, organ or tissue transplant?

☐ Yes (donated) ☐ Yes (received) ☐ No ☐ Unknown

If yes: Type of Product: ☐ Blood ☐ Blood products ☐ Organ/tissue

Donation date(s): ____/____/_____; ____/____/_____; ____/____/_____

Transfusion/transplant date(s): ____/____/_____; ____/____/_____; ____/____/_____

Blood Collection Agency/Medical Facility: _____

In the **2 weeks** prior to symptom onset (or **~8 weeks** prior to collection date for asymptomatic patients):

Was the patient exposed to a triatomine? ☐ Yes ☐ No ☐ Unknown

If yes, please provide details: _____

_____

Did the patient travel outside his/her county of residence? ☐ Yes ☐ No ☐ Unknown

If yes, please provide details below:

Country	City/State	How Long	From (date)	To (date)	Rural area?
					☐ Yes ☐ No ☐ Unk
					☐ Yes ☐ No ☐ Unk
					☐ Yes ☐ No ☐ Unk

Did the patient consume any food containing açaí berries or drink açaí berry juice, imported raw sugar cane juice, palm wine, or fresh squeezed juice from an unregulated vendor? ☐ Yes ☐ No ☐ Unknown

If yes, please provide details: _____

_____

NBS Patient ID: _____ Patient Name: _____

Other pertinent information:

Epidemiology: Part B
For CHRONIC SYMPTOMATIC OR INDETERMINATE Chagas Disease cases, complete this section
For ACUTE Chagas Disease cases, go back to PART A

Part B: CHRONIC SYMPTOMATIC OR INDETERMINATE Chagas Disease cases

Has the patient ever lived outside of the United States for more than 60 days (*please include travel where stay was >60 days*)?

Country	City/State	How Long	From (date)	To (date)	Rural area?
					☐ Yes ☐ No ☐ Unk
					☐ Yes ☐ No ☐ Unk
					☐ Yes ☐ No ☐ Unk

Does the patient have a history of contact with triatomines? ☐ Yes ☐ No ☐ Unknown

_____

_____

Has the patient consumed any food containing açaí berries or drank açaí berry juice, imported raw sugar cane juice, palm wine, or fresh squeezed juice from an unregulated vendor? ☐ Yes ☐ No ☐ Unknown

If yes, please provide details: _____

_____

Has the patient ever received a blood transfusion, organ or tissue transplant?

☐ Yes ☐ No ☐ Unknown

If yes: Type of Product: ☐ Blood ☐ Blood products ☐ Organ/tissue

Transfusion/transplant date(s): ____/____/_____; ____/____/_____; ____/____/_____

Blood Collection Agency/Medical Facility: _____

_____

Other pertinent information:

Treatment

Did the patient receive treatment? ☐ Yes ☐ No ☐ Unknown

If yes, provide details:

☐ Benznidazole Dosage: _____ Date Started: ____/____/_____ Ended: ____/____/_____

☐ Nifurtimox Dosage: _____ Date Started: ____/____/_____ Ended: ____/____/_____

NBS Patient ID: _____ Patient Name: _____

Comments or Other Pertinent Epidemiological Data

Completed by Investigating Agency
Date First Reported: ____/____/_____ Investigation: Started ____/____/_____ Completed ____/____/_____
Reporting Facility: _____
Name of Investigator: _____ (Please print clearly)
Agency: _____ (Please do not abbreviate)
Phone: _____ E-Mail: _____