For Use by DSHS Central Office Only
Approved By: _____ Date: ___________
MMWR Year: ______

☐ Acute
☐ Chronic
☐ Congenital

Chagas Disease Case Investigation Form

NBS Patient ID: ________________________

PLEASE PRINT LEGIBLY

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a Case

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)*

For Acute & Congenital Chagas cases, complete Part A below.

For Chronic Chagas cases, complete Part B on Page 3.

Clinical Evidence for Acute and Congenital Cases (Part A)

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

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Epidemiology for Acute and Congenital Cases (Part A)

ACUTE and CONGENITAL* 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:

*Because the infected mother's antibody to *T. cruzi* can persist in her infant for up to 9 – 12 months, serologic testing is not useful for detecting congenital infection in newborn infants. Over time, the mother's antibody will disappear and children who are uninfected should be antibody negative by 9 – 12 months of age. Congenital disease is confirmed by the detection of *T. cruzi* parasites in blood smears or molecular evidence of *T. cruzi* DNA in blood collected within 3 months of delivery to gestational parent, in addition to the absence of other known routes of transmission. If congenital Chagas disease is suspected, the gestational parent should be serologically tested.

If patient is an infant, provide serology results for gestational parent:

Test	DOC	Titer/Value	Interpretation	Lab Name
T. cruzi IgG ELISA (Hemagen)			☐ Positive ☐ Negative	
T. cruzi IgG ELISA (Wiener)			☐ Positive ☐ Negative	
T. cruzi Lateral Flow Assay			☐ Positive ☐ Negative	
T. cruzi AB IB (TESA)		N/A	☐ Positive ☐ Negative	

NBS Patient ID: ______________________ Patient Name: ________________________________

Clinical Evidence for Chronic Cases, if Symptomatic (Part B)

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

Epidemiology for Chronic Cases (Part B)

CHRONIC 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*) OR recall any travel where there was significant potential for triatomine exposure?

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

If yes, please provide details:

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:

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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	
T. cruzi IgG ELISA (Hemagen)			☐ Positive ☐ Negative	
T. cruzi IgG ELISA (Wiener)			☐ Positive ☐ Negative	
T. cruzi Lateral Flow Assay			☐ Positive ☐ Negative	
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): ____

Treatment

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

If yes, provide details:

☐ Benznidazole Dosage: __________ Date Started: ____/____/______ Ended: ____/____/______

☐ Nifurtimox Dosage: __________ Date Started: ____/____/______ Ended: ____/____/______

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: ____