

## Chagas Disease Case Surveillance Report

**Patient Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parish: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Patient's place of birth (city, state, country): \_\_\_\_\_

Occupation: \_\_\_\_\_

**Laboratory Testing:**

Reason for Lab Test:  Blood Donation  Diagnosis  Other \_\_\_\_\_

Specimen Type	Lab Test *	Collection Date	Result

\* **Laboratory Tests may include:** ELISA, RPIA, Thin or Thick Smear, PCR, IFA (specify titer), Complement Fixation (specify titer), Hemoagglutination, Zenodiagnosis

**Travel: If yes to any of the following, please fill in table below**

Have you ever been an immigrant, refugee, citizen or resident (lived > 5 years in) another country?

Yes  No

Have you traveled outside of the United States to another country?

Yes  No

Were you ever a member of the military? If yes did you spend time outside of the United States?

Yes       No

Country	City/State	Length of Travel	Date of Travel	Rural (Y/N)

Have you ever been homeless?

Yes       No      If yes where? \_\_\_\_\_

Do you or have you taken part in outdoor activities that include camping or sleeping outdoors?

Yes       No      If yes where? \_\_\_\_\_

Have you ever observed Triatomine bugs inside your home?

Yes       No

**Blood Exposure History:      If yes to any of the following, please fill in table below**

Have you ever received a blood transfusion or blood product therapy?

Yes       No

Have you ever received a transplant, such as organ, tissue, bone marrow, cornea, etc?

Yes       No

Have you ever received a bone or skin graft?

Yes       No

Have you ever had surgery?

Yes       No

Have you ever come into contact with someone else's blood?

Yes       No      What happened?: \_\_\_\_\_

Have you ever experienced an accidental needle stick?

Yes       No

Procedure	Location (City/State,Country)	Name of Facility	Date of Procedure

**Medical History:**

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> Symptomatic  | <input type="checkbox"/> HIV/AIDS                         | <input type="checkbox"/> Immunosuppressive condition |
| <input type="checkbox"/> Asymptomatic | <input type="checkbox"/> Blood Transfusion (date: _____ ) |  |
| <input type="checkbox"/> Pregnant     | <input type="checkbox"/> Breast Feeding                   | <input type="checkbox"/> Other: _____                |

**Symptoms:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Malaise                 | <input type="checkbox"/> Diarrhea              |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Syncope                 | <input type="checkbox"/> Lymphadenopathy       |
| <input type="checkbox"/> Hepatosplenomegaly     | <input type="checkbox"/> Chagoma                 | <input type="checkbox"/> Romana Sign           |
| <input type="checkbox"/> Mega Esophagus         | <input type="checkbox"/> Meningoencephalitis     | <input type="checkbox"/> Chest Pain            |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Swelling of feet/ankles | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Vomiting               | <input type="checkbox"/> Mega Colon              | <input type="checkbox"/> Heart Ahythmias       |
| <input type="checkbox"/> Myocarditis            |  |  |

**Treatment:**

- |                                  |                                     |                                       |                                       |
|----------------------------------|-------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Treated | <input type="checkbox"/> Nifurtimox | <input type="checkbox"/> Benznidazole | <input type="checkbox"/> Other: _____ |
|----------------------------------|-------------------------------------|---------------------------------------|---------------------------------------|

Outcome: \_\_\_\_\_ Date of Death: \_\_\_\_\_

Case Classification: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Comments: \_\_\_\_\_

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Interviewer: \_\_\_\_\_

Date: \_\_\_\_\_