



FLORIDA CHAGAS INFECTION CASE REPORT

Date of Report: _____

1. County _____

2. Name (Last, First) _____

3. Sex
 Male Female

4. DOB (mm/dd/yyyy) _____

5. Telephone _____

6. Address (No. & Street) _____

(City) _____

(State) _____

(Zip) _____

7. Race/Ethnicity White Black Hispanic Asian/Pacific Islander
 American Indian/Alaska Native Unknown/Not specified

8. Identified by blood bank screening?
 Yes No Unknown

9. Blood bank (Name, Address, Zip, Telephone) _____

10. Symptoms (Check all that apply)
 None Headache Anorexia Fever Diarrhea Rash
 Vomiting Myalgia Fatigue Bloating Constipation
 Heart failure Other _____
Date of Symptom Onset (mm/dd/yyyy): ____/____/____
Is patient currently symptomatic? Yes No Unknown

11. Laboratory Results (please attach copy of results) *Blood banks will confirm results detected by routine screening

Sample Type	Date Collected (mm/dd/yyyy)	Laboratory Name	Test Type (IFA, RIPA, ELISA)	Lab Report Date (mm/dd/yyyy)	Results

Risk Factor Information

12. Is the patient originally from, or has the patient traveled to, an area endemic for Chagas disease (Mexico, Central America, or South America)? Yes No Unknown

If yes, Country _____ Dates of Travel/Residence (mm/dd/yyyy) ____/____/____ to ____/____/____
Date of Arrival/Return to the U.S. (mm/dd/yyyy) ____/____/____

13. Is the patient a child of Latin American immigrants? Yes No Unknown

14. Is the patient currently pregnant? Yes No Unknown Not applicable

If yes, weeks pregnant _____ Due date (mm/dd/yyyy) ____/____/____

15. Is the patient breastfeeding or planning to breastfeed? Yes No Unknown Not applicable

Treatment/Family Information

16. Is the patient receiving treatment for Chagas disease? Yes No Unknown

If yes, please specify type and duration _____

17. Does the patient have any family members that need testing? (Family members should be tested if they have received organs/blood from the patient; if they have history of residence in or travel to Chagas endemic countries; or if they are the children of an infected mother)

Yes No Unknown

If yes, please list names and relationship:

Name _____ Relationship to patient _____

Comments:

Date _____ Investigator _____ (Please print) Phone (____) _____

Instructions for completing the form “Florida Chagas Infection Case Report”, 6/07

The purpose of this form is to collect information about Florida residents infected with Chagas disease. It should be used by county health department staff when investigating a Chagas disease case. Use of this form is suggested, but not mandatory. Individuals are not required to provide the information on this form.

1. **County:** Provide the county of residence for the individual being investigated.
2. **Name:** Provide the first and last name of the individual.
3. **Sex:** Indicate if the individual is male or female.
4. **DOB:** Provide the individual's date of birth.
5. **Telephone:** Enter the individual's contact telephone number.
6. **Address:** Enter the individual's address, including number and street, city, state, and zip code.
7. **Race/Ethnicity:** Check the appropriate box to select the individual's race and ethnicity. More than one box can be checked if needed.
8. **Identified by Blood Bank Screening:** Check the appropriate box to indicate whether the individual being investigated was initially notified of his/her positive status by a blood bank that had screened his/her donation.
9. **Blood Bank contact information:** Enter the name, address (including street, city, and zip code), and contact telephone number for the blood bank that screened the donation.
10. **Symptoms:** Check the boxes to indicate which symptoms the individual has experienced. Ask the individual if he/she has experienced any symptoms not listed, and enter these on the line for “other”. Record the date on which the individual first became symptomatic, and select the appropriate box depending on if he/she is currently experiencing symptoms.
11. **Laboratory Results:** For each laboratory test performed, enter the sample type (serum, whole blood, etc.), the date the sample was collected, the name of the laboratory that performed the test, the type of test performed, the date the laboratory reported results, and the result of the test (positive, negative, inconclusive, etc.).
12. **Origin/Travel History:** Determine if the individual is either originally from, or has traveled to, a Chagas endemic country. This includes Mexico and countries in South America and Central America. If yes, enter the country, the beginning and end dates of travel/residence, and the date the individual arrived in/returned to the U.S.
13. **Parents:** Check the appropriate box depending on whether the individual is a child of Latin American immigrants.
14. **Pregnancy status:** Check the appropriate box depending on whether the individual is pregnant. If yes, enter the weeks pregnant and the due date.
15. **Breastfeeding:** Check the appropriate box depending on if the individual is currently breastfeeding or planning to breastfeed.
16. **Treatment:** Check the appropriate box to indicate if the individual is receiving treatment for Chagas disease. If yes, please specify the type and duration of the treatment.
17. **Family:** Enter the names of any family members that may have been exposed to Chagas and need testing. Family members should be tested if they have received organs/blood from the individual for whom this form is being completed; if they have history of residence in or travel to Chagas- endemic countries; or if they are the children of an infected mother.
18. **Comments:** Enter any additional comments about the individual that were not captured in the form.