



# Arizona Chagas Disease Case Investigation Form

## Patient Information

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
 Patient's place of birth (*city, state or providence, country*): \_\_\_\_\_  
 Mother's place of birth (*city, state or providence, country*): \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 County ID#: \_\_\_\_\_ State ID#: \_\_\_\_\_  
 Date received by County: \_\_\_\_\_

## Screening

Specimen type	Lab test	Collection date	Final date	Result

## Medical history

- Symptomatic: \_\_\_\_\_  
 Immunosuppressive condition     HIV/AIDS     Blood transfusion (date: \_\_\_\_\_)  
 Organ transplant (date: \_\_\_\_\_)  
 Pregnant     Breast feeding     Other: \_\_\_\_\_

## Symptoms

- |   |                                  |  |   |
|---|----------------------------------|--|---|
| <input type="checkbox"/> Fever              | <input type="checkbox"/> Malaise | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Vomiting         |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Syncope | <input type="checkbox"/> Lymphadenopathy | <input type="checkbox"/> Mega colon       |
| <input type="checkbox"/> Hepatosplenomegaly | <input type="checkbox"/> Chagoma | <input type="checkbox"/> Romana sign     | <input type="checkbox"/> Heart arhythmias |

- Mega esophagus       Meningoencephalitis       Chest pain       Myocarditis  
 Breathing difficulties       Swelling in feet/ankles       Difficulty swallowing

### Laboratory Results:

- ELISA- Repeat reactive       RPIA- Confirmed       Thick or thin blood smear  
 PCR       IFA (Titer: \_\_\_\_\_)       Comp. Fix (Titer: \_\_\_\_\_)  
 Hemagglutination       Xenodiagnosis

### Treatment

Treated:  Nifurtimox     Benznidazole \_\_\_\_\_

### Travel

Countries where patient has lived/traveled other than the United States:

Country	City/State	How long?	When?	Rural
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

### Outcome

\_\_\_\_\_ Date of death: \_\_\_\_\_

### Classification

This case is \_\_\_\_\_

### Interviewee

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

### Physician

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Hospital/Affiliation: \_\_\_\_\_

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

**Comments**

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Revision: 2/29/16