

**Tennessee Department of Health
Chagas Disease Form**

Revised: 08/2010

Please fill out this form as completely as possible and send or fax to Central Office: Tennessee Department of Health, Communicable and Environmental Disease Services, 1st Floor, Cordell Hull Bldg., 425 5th Ave. North, Nashville, TN 37243, Phone: 615.741.7247 Fax: 615.741.3857

DEMOGRAPHICS

CASE ID#: _____

Name Last: _____ First: _____ Middle: _____ DOB: ____/____/____
 Reported Age: _____ □ Days □ Months □ Years Sex: □ Male □ Female □ Unknown
 Street Address: _____
 City: _____ County: _____ State: _____ Zip: _____
 Phone - Home: _____ Work: _____ Cell: _____
 Ethnicity: □ Hispanic Race: □ American Indian / Alaskan □ Asian □ Black / African American
 □ Not Hispanic □ Hawaiian / Pacific Islander □ White □ Other

INVESTIGATION SUMMARY

Investigator Name _____ Jurisdiction _____

BLOOD BANK	Identified by blood bank screening? □ Yes □ No □ Unknown	Blood Bank (name, address, zip, phone): _____ _____ _____
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INVESTIGATION	Investigation Start Date: ____/____/____ Investigation Status: □ Open □ Closed Physician: _____	HOSPITAL	Was the patient hospitalized for this illness? □ Yes (Hospital: _____) □ No □ Unknown Admission: ____/____/____ Discharge Date: ____/____/____ Illness Onset Date: ____/____/____
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LABORATORY

SEROLOGY	Serologic Test:	Serology 1	Titer/ Units	Pathogen	Date	Serology 2	Titer/ Units	Pathogen	Date
		□ Pos □ Neg				□ Pos □ Neg			
		□ Pos □ Neg				□ Pos □ Neg			
		□ Pos □ Neg				□ Pos □ Neg			

LABORATORY CONTACT	Name of Primary Laboratory: _____ City/ State: _____ Specimen: _____ Name of Secondary Laboratory: _____ City/ State: _____ Specimen: _____	OTHER TESTS	Direct microscopy □ Positive □ Negative Test date _____
			PCR □ Positive □ Negative Test date _____
			Culture □ Positive □ Negative Test date _____

RISK FACTORS

CLINICAL INFORMATION

Is the patient originally from an area endemic for Chagas disease? (Latin America)
□ Yes □ No □ Unknown

Has the patient traveled to an area endemic for Chagas disease?
□ Yes □ No □ Unknown

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

Is the patient pregnant?
□ Yes □ No □ Unknown
(If yes, weeks pregnant _____ due date _____)

Is the patient breastfeeding or planning to breastfeed?
□ Yes □ No □ Unknown

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

Are there any family members who require testing? (ie, if they have received organs/
blood from the patient, history of travel, or children of infected mother)
□ Yes □ No □ Unknown

Comments _____

Transfusion/ organ transplant recipient?
□ Yes □ No □ Unknown

Did the patient donate blood/organ?
□ Yes □ No □ Unknown

Currently Symptomatic? □ Yes □ No □ Unknown

Symptoms:
 □ None □ Headache □ Anorexia
 □ Vomiting □ Fever □ Fatigue
 □ Myalgia □ Diarrhea □ Constipation
 □ Bloating □ Rash □ Heart failure
 □ Other cardiac manifestation
 □ Gastrointestinal manifestation

Did the patient die? □ Yes □ No □ Unknown

CASE STATUS

□ Confirmed □ Suspect
 □ Probable □ Noncase