Washington State Department of HEALTH

Chagas Disease

County

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ ☐ Years ☐ Months

Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional)_____

LHJ notification date ___/___/___

Classification

☐ Classification pending ☐ Confirmed ☐ Investigation in progress ☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status

☐ Complete ☐ Complete – not reportable to DOH ☐ Unable to complete Reason _____ ☐ In progress

Dates: **Investigation start** ___/___/__ Investigation complete ___/___/__ Record complete ___/___/__ **Case complete** ___/___/__

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: ☐ Female ☐ Male ☐ Other ☐ Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity ☐ Hispanic, Latino/a, Latinx ☐ Non-Hispanic, Latino/a, Latinx ☐ Patient declined to respond ☐ Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race ☐ Amer Ind/AK Native (***specify***: ☐ Amer Ind ***and/or*** ☐ AK Native) ☐ Asian ☐ Black or African American
☐ Native HI/Pacific Islander (***specify***: ☐ Native HI ***and/or*** ☐ Pacific Islander) ☐ White ☐ Patient declined to respond ☐ Unk

Additional race information:

☐ Afghan ☐ Afro-Caribbean ☐ Arab ☐ Asian Indian ☐ Bamar/Burman/Burmese ☐ Bangladeshi ☐ Bhutanese
☐ Central American ☐ Cham ☐ Chicano/a or Chicanx ☐ Chinese ☐ Congolese ☐ Cuban ☐ Dominican ☐ Egyptian
☐ Eritrean ☐ Ethiopian ☐ Fijian ☐ Filipino ☐ First Nations ☐ Guamanian or Chamorro ☐ Hmong/Mong
☐ Indigenous-Latino/a or Indigenous-Latinx ☐ Indonesian ☐ Iranian ☐ Iraqi ☐ Japanese ☐ Jordanian ☐ Karen
☐ Kenyan ☐ Khmer/Cambodian ☐ Korean ☐ Kuwaiti ☐ Lao ☐ Lebanese ☐ Malaysian ☐ Marshallese ☐ Mestizo
☐ Mexican/Mexican American ☐ Middle Eastern ☐ Mien ☐ Moroccan ☐ Nepalese ☐ North African ☐ Oromo
☐ Pakistani ☐ Puerto Rican ☐ Romanian/Rumanian ☐ Russian ☐ Samoan ☐ Saudi Arabian ☐ Somali
☐ South African ☐ South American ☐ Syrian ☐ Taiwanese ☐ Thai ☐ Tongan ☐ Ugandan ☐ Ukrainian
☐ Vietnamese ☐ Yemeni ☐ Other: _____

What is your (your childs) preferred language? Check one:

☐ Amharic ☐ Arabic ☐ Balochi/Baluchi ☐ Burmese ☐ Cantonese ☐ Chinese (unspecified) ☐ Chamorro ☐ Chuukese
☐ Dari ☐ English ☐ Farsi/Persian ☐ Fijian ☐ Filipino/Pilipino ☐ French ☐ German ☐ Hindi ☐ Hmong ☐ Japanese
☐ Karen ☐ Khmer/Cambodian ☐ Kinyarwanda ☐ Korean ☐ Kosraean ☐ Lao ☐ Mandarin ☐ Marshallese ☐ Mixteco
☐ Nepali ☐ Oromo ☐ Panjabi/Punjabi ☐ Pashto ☐ Portuguese ☐ Romanian/Rumanian ☐ Russian ☐ Samoan
☐ Sign languages ☐ Somali ☐ Spanish/Castilian ☐ Swahili/Kiswahili ☐ Tagalog ☐ Tamil ☐ Telugu ☐ Thai ☐ Tigrinya
☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ Other language: _____ ☐ Patient declined to respond ☐ Unknown

Interpreter needed ☐ Yes ☐ No ☐ Unk

Case Name _____ LHJ Case ID _____

EMPLOYMENT AND SCHOOL

Employed ☐ Yes ☐ No ☐ Unk Occupation _____ Industry _____

Employer _____ Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk

Type of school ☐ Preschool/day care ☐ K-12 ☐ College ☐ Graduate School ☐ Vocational ☐ Online ☐ Other

School name _____ School address _____

City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____

OK to talk to patient (If Later, provide date) ☐ Yes ☐ Later ___/___/___ ☐ Never

Date of interview attempt ___/___/___ ☐ Complete ☐ Partial ☐ Unable to reach ☐ Patient could not be interviewed

Alternate contact: ☐ Parent/Guardian ☐ Spouse/Partner ☐ Friend ☐ Other _____

Name _____ Phone _____

Outbreak related ☐ Yes ☐ No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___

Clinical Features

Identified as acute, congenital, or chronic ☐ Acute ☐ Congenital ☐ Chronic ☐ Unknown

Y	N	Unk	
☐	☐	☐	Asymptomatic (no clinical illness)
☐	☐	☐	Nausea/vomiting
☐	☐	☐	Diarrhea
☐	☐	☐	Rash
☐	☐	☐	Arthralgia (joint pain)
☐	☐	☐	Headache
☐	☐	☐	Lymphadenopathy
☐	☐	☐	Acute myocarditis
☐	☐	☐	Romaña's sign (eyelid swelling)
☐	☐	☐	Chagoma (localized swelling at site of infection)
☐	☐	☐	Hepatomegaly
☐	☐	☐	Splenomegaly
☐	☐	☐	Meningoencephalitis
☐	☐	☐	Any fever, subjective or measured If yes, Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF

If no,

Y	N	Unk	
☐	☐	☐	Used OTC medications that reduced fever
☐	☐	☐	Other potential reason for lack of fever _____

Y	N	Unk	
☐	☐	☐	Heart arrhythmia
☐	☐	☐	Conduction abnormalities
☐	☐	☐	Cardiomyopathy
☐	☐	☐	Cardiomegaly
☐	☐	☐	Heart failure
☐	☐	☐	Difficulty swallowing or passing stool (megaesophagus or megacolon)
☐	☐	☐	Chest pain
☐	☐	☐	Syncope
☐	☐	☐	Dizziness
☐	☐	☐	Pneumonitis
☐	☐	☐	Anasarca (severe swelling of the whole body)

Infant only

Y	N	Unk	
☐	☐	☐	Low birth weight
☐	☐	☐	Premature birth
☐	☐	☐	Low apgar scores (<4)

Clinical Testing

Y N Unk

☐ ☐ ☐ Thrombocytopenia *Thrombocytopenia defined as platelets < 100,000 /mm^3* Lowest platelet count _____
☐ ☐ ☐ Anemia (Hb < 11, Hct < 33)

Predisposing Conditions

Y N Unk
☐ ☐ ☐ Immunosuppressive therapy or condition, or disease _____
☐ ☐ ☐ Left ventricular dysfunction
☐ ☐ ☐ Heart failure
☐ ☐ ☐ Atrial fibrillation
☐ ☐ ☐ Myocardial fibrosis
☐ ☐ ☐ Non-sustained ventricular tachycardia (arrhythmia)

Hospitalization

Y N Unk
☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Y N Unk
☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk
☐ ☐ ☐ **Died of this illness** Death date ___/___/___ *Please fill in the death date information on the Person Screen*
☐ ☐ ☐ Autopsy performed
☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition

Pregnancy

Pregnancy status at time of symptom onset or time of positive screening test

☐ Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at symptom onset or testing _____
OB name, phone, address _____
Outcome of pregnancy ☐ Still pregnant ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – singleton ☐ Delivered – multiple ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk
Facility/Location of birth _____

☐ Postpartum Delivery date ___/___/___
OB name, phone, address _____
Outcome of pregnancy ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – singleton ☐ Delivered – multiple ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk
Facility/Location of birth _____

☐ Neither pregnant nor postpartum ☐ Unk

Infant screening

Y N Unk
☐ ☐ ☐ Was cord blood collected at birth? Collection date:__/__/__
☐ ☐ ☐ Was this specimen tested? Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unk
☐ ☐ ☐ Was infant whole blood collected 4-6 weeks after birth?
☐ ☐ ☐ Recommended collection date: __/__/__ Actual Collection date: __/__/__
☐ ☐ ☐ Was this specimen tested? Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unk
☐ ☐ ☐ Was infant serum collected 9-12 months after birth? ☐ Yes ☐ No
☐ ☐ ☐ Recommended collection date: __/__/__ Actual Collection date: __/__/__
☐ ☐ ☐ Was this specimen tested? Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unk
☐ ☐ ☐ If positive, WDRS event ID for infant _____

TREATMENT

Y N Unk
☐ ☐ ☐ Did patient receive treatment
Specify medication ☐ Nifurtimox ☐ Benznidazole
☐ Other _____
Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___
Prescribed dose _____ ☐ g ☐ mg ☐ ml Frequency _____ Duration _____ ☐ Days ☐ Weeks ☐ Months
Did patient take medication as prescribed ☐ Yes ☐ No - Why not _____ ☐ Unk
Prescribing provider _____

RISK AND RESPONSE

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____	☐ County/City _____ ☐ State _____ ☐ Country _____	☐ County/City _____ ☐ State _____ ☐ Country _____

	☐ Other _____	☐ Other _____	☐ Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ **Is case a foreign arrival (e.g. immigrant, refugee, adoptee, visitor) from an endemic country (continental Latin America)** **Country** _____ Duration of residence _____

Date of departure from endemic country ___/___/___

☐ ☐ ☐ **Is case's gestational parent a foreign arrival (e.g. immigrant, refugee, adoptee, visitor), previous resident or current resident of an endemic country (continental Latin America)** **Country** _____

☐ ☐ ☐ Does the case know anyone else who has tested positive for Chagas disease?

Contact setting/relationship to case ☐ Household contact ☐ Travel contact ☐ Other

☐ ☐ ☐ **Exposure to triatomine bugs (kissing bug; chinchorro, el bicho besadore, chinche, vinchuca [Spanish]; barbeiro [Brazilian Portuguese])** Date of exposure ___/___/___

Location of exposure ☐ Multiple exposures ☐ Other country ☐ Other state ☐ Unk

Specify location _____

☐ ☐ ☐ Has the case ever consumed any food or beverages linked to a known outbreak of *T. cruzi*?

Associated food/beverage _____

☐ ☐ ☐ **Blood transfusion or blood products (e.g., IG, factor concentrates) recipient** Date ___/___/___

☐ ☐ ☐ **Organ or tissue transplant recipient** Date ___/___/___

☐ ☐ ☐ (Potential) Occupational exposure

☐ ☐ ☐ Lab worker

☐ ☐ ☐ Other Occupation _____

☐ ☐ ☐ **Reason for testing** ☐ Blood or organ donor screening ☐ Blood or organ recipient screening

☐ Prenatal screening of gestational parent

☐ Infant screening of child born to gestational parent with Chagas disease

☐ Case is foreign arrival from endemic country

☐ Case born to gestational parent who was born in or lived >6 months in an endemic country prior to delivery

☐ Case was exposed to triatomine bugs within the 3 months prior to specimen collection

☐ Other _____

Infant Only

Y N Unk

☐ ☐ ☐ **Gestational parent had lab evidence of Chagas disease during pregnancy**

Gestational parent WDRS ID _____

☐ ☐ ☐ **Breast fed**

☐ ☐ ☐ Did the infant ever test negative for Chagas disease? Date of negative test __/__/__

☐ ☐ ☐ Did the breastfeeding parent report feeding the infant while nipples were bleeding or cracked?

☐ ☐ ☐ What stage of disease was the breastfeeding parent in while breastfeeding? ☐ Acute ☐ Chronic ☐ Unk

☐ ☐ ☐ **Infected in utero**

☐ No risk factors or likely exposures could be identified

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ **Epi-linked to a confirmed or probable case**

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____

☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Vectorborne ☐ Blood products ☐ Congenital ☐ Unk ☐ Other

_____

Describe _____

Exposure summary

Public Health Issues

Y N Unk

☐ ☐ ☐ **Did case donate blood products in the time since presumed exposure?** Date ___/___/___
Agency/location _____ Type of donation _____

☐ ☐ ☐ **Did case donate organs or tissue (including ova or semen) in the time since presumed exposure?**
Date ___/___/___
Agency/location _____ Type of donation _____

☐ ☐ ☐ **Are there any family members who require screening?**
Reason for screening: ☐ Child of infected birth mother ☐ Received blood or organ donation(s) from family member
☐ Shared history of travel or residence in endemic region ☐ Other _____

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Breastfeeding education provided
☐ ☐ ☐ Notified blood or tissue bank (if case has ever donated)
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Notified family members of screening recommendations, if any
☐ ☐ ☐ Any other public health action _____

NOTES

LAB RESULTS

Lab report information

Lab report reviewed – LHJ ☐

WDRS user-entered lab report note

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen

Specimen identifier/accession number _____

Specimen collection date ___/___/___ Specimen received date ___/___/___

WDRS specimen type _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result

WDRS test performed _____

WDRS test result, coded _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending

Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending

Result date ___/___/___

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Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____

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