TOXOPLASMOSIS CASE REPORT FORM

Georgia Division of Public Health

(leave this section blank for state health department use) Report Status: ☐Confirmed ☐ Probable ☐ Suspect ☐Revoked

A. DEMOGRAPHIC INFORMATION

Last Name: First Name: MI:

Address: Apt. #:

City: State: Zip: County:

Unique Address Condition: ☐ Homeless ☐Incarcerated

Contact phone: (____) _____-_____ Occupation:

Birth date: _____/_____/_____ Place of birth (e.g. specific country):

Age: _____ ☐Years ☐Months ☐Weeks ☐Days ☐Unk

Sex: ☐Female ☐Male ☐Transgender ☐Unk

Race *(check all that apply):*
☐American Indian/ Alaskan Native ☐Asian ☐Black/ African American ☐Multiracial
☐Native Hawaiian/Pacific Islander ☐White ☐Other please specify _____ ☐Unk

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unk

B. CLINICAL INFORMATION

Physician name and address:

Physician phone: (_____) _____-_____ Patient record/ chart #:

Reason for test: ☐Baseline titer ☐ Diagnosis of Clinical Syndrome (If diagnosis please indicate below:)

☐ Acute Toxoplasmosis Syndrome (Complete all sections) ☐Congenital infection (Complete all sections)

☐ Reactivation associated with immune compromise (Previous titer information ☐Yes _____ ☐No ☐Unk

Diagnosis date: _____/_____/_____

Did case have any symptoms? ☐Yes ☐No ☐Unk Symptom onset date: _____/_____/_____
Duration of symptoms: _____ ☐Days ☐Weeks ☐Months

Chorioretinitis	☐Yes	☐No	☐Unk	Convulsions	☐Yes	☐No	☐Unk
Encephalitis	☐Yes	☐No	☐Unk				
Fever	☐Yes (highest temp._____°F/°C)		☐No ☐Unk	Headache	☐Yes	☐No	☐Unk
Hepatomegaly	☐Yes	☐No	☐Unk	Hydrocephaly	☐Yes	☐No	☐Unk
Intracerebral lesions/calcification	☐Yes	☐No	☐Unk	Jaundice	☐Yes	☐No	☐Unk
Lymphadenopathy	☐Yes	☐No	☐Unk	Malaise	☐Yes	☐No	☐Unk
Microcephaly	☐Yes	☐No	☐Unk	Muscle aches	☐Yes	☐No	☐Unk
Myocarditis	☐Yes	☐No	☐Unk	Pneumonia	☐Yes	☐No	☐Unk
Pneumonitis	☐Yes	☐No	☐Unk	Rash	☐Yes	☐No	☐Unk
Splenomegaly	☐Yes	☐No	☐Unk	Sore throat	☐Yes	☐No	☐Unk

Other (*specify*): _____

Did case have an underlying illness? ☐Yes ☐No ☐Unk
If yes, select all that apply: ☐ Immunocompromised ☐Other (specify:_____)

Case hospitalized? ☐Yes ☐No ☐Unk Date hospitalized: _____/_____/_____

Hospital name: Date discharged: _____/_____/_____

Outcome: ☐ Died ☐ Recovered ☐Unk Date of death: _____/_____/_____

C. DIAGNOSTIC LABORATORY TEST INFORMATION

Was laboratory testing done? ☐Yes ☐No ☐Unk Name of Laboratory: _____

Source: ☐Blood ☐Fluid ☐Tissue ☐Other (*specify*): _____

Test	Positive	Negative	Equivocal	Not done	Unk	Date
IgM	☐	☐	☐	☐	☐	_____/_____/_____
IgA	☐	☐	☐	☐	☐	_____/_____/_____
IgG	☐	☐	☐	☐	☐	_____/_____/_____

If IgG positive, fourfold rise in IgG? ☐Yes ☐No ☐Unk
Type/method of test, if known: _____

Culture	☐	☐	☐	☐	☐	_____/_____/_____
Histopathologic	☐	☐	☐	☐	☐	_____/_____/_____
CT/MRI	☐	☐	☐	☐	☐	_____/_____/_____

Other (*specify):*_____

D. INFORMATION RELEVANT TO EXPOSURE, CONTROL AND PREVENTION

Is this a congenital case? ☐Yes ☐No ☐Unk

If **yes**, Complete the following information about the Mother:
Name: _____ DOB_____/_____/_____ Occupation:_____
Was the Mother tested for Toxoplasmosis? ☐Yes ☐No ☐Unk
(attach all copies of lab results, regardless of positive or negative result)
Did the Mother have any symptoms? ☐Yes ☐No ☐Unk Symptom onset date: _____/_____/____
Duration of symptoms: _____ ☐Days ☐Weeks ☐Months
Did Mother have an underlying illness? ☐Yes ☐No ☐Unk
If yes select all that apply: ☐Immunocompromised ☐Other:_____

Complete the next section if *Toxoplasma* infection is acutely acquired or congenital:
IN THE 25 DAYS BEFORE SYMPTOM ONSET, DID THE CASE (OR MOTHER IF CASE IS CONGENTITAL):

Receive organ or blood products? ☐Yes ☐No ☐Unk
If yes, Date: ____/____/_____ Type: _____
Travel out-of-state or out-of-country? ☐Yes ☐No ☐Unk
If yes, specify when: _____/_____/_____ to _____/_____/_____
If yes, specify where: City: _____ State: _____ Country :_____
Have exposure to a natural water body (e.g. stream, river, lake, etc)? ☐Yes ☐No ☐Unk
If yes, Date: ____/____/_____
If yes, activity: ☐ Boating/canoing ☐ Camping
☐ Eco-challenge ☐ Swimming
☐ Triathalon or similar ☐ Other: _____
Have exposure to soil (e.g. gardening, sand, etc)? ☐Yes ☐No ☐Unk
If yes, Date: ____/____/_____
If yes, activity: _____
Is normal drinking water filtered? ☐Yes ☐No ☐Unk
Please specify what is normal drinking water (e.g. well, city, bottled, etc):_____
Is there a well on property? ☐Yes ☐No ☐Unk
If yes, is well chlorinated? ☐Yes ☐No ☐Unk

IN THE 25 DAYS BEFORE SYMPTOM ONSET, DID THE CASE (OR MOTHER IF CASE IS CONGENITAL)**:**

Have any contact with animals/pets? ☐ Yes (*complete box below*) ☐ No ☐ Unk

Type of Animal	Exposure date(s)	Exposure location (Facility/Farm/Home/Other)	City	State	Country
☐ Bird					
☐ Cat (Please answer questions below)					
☐ Dog					
☐ Ferret					
☐ Mouse					
☐ Other pet Specify: _____					
☐ Other Specify: _____					

If **cat**, please complete the following information about the animal:

Age of cat: _____ Indoor cat? ☐ Yes ☐ No ☐ Unk

Cat's diet: ☐ Canned food ☐ Commercial dry food ☐ Other (specify): _____ ☐ Unk

Was there any contact with litter in the litter box (e.g. cleaning the litter box)? ☐ Yes ☐ No ☐ Unk

Consume high-risk animal products (raw or undercooked meat)? ☐ Yes (complete box below) ☐ No ☐ Unk

Product Type (specify)	Type of Meat/Animal	Date Purchased/ Obtained	Where Purchased/ Obtained	Purchased? (YES/NO)	Date Consumed	Country or State of Origin (if known)
☐ Wild Game						
☐ Farmed Animal e.g. locally grown or personally owned						
☐ Shellfish						
☐ Grocery, restaurant, market, meat purchase						
☐ Other: _____						

ADMINISTRATIVE INFORMATION

Comments:_____

_____

Investigator's name: _____ Phone: (____) _____ - _____

Agency: _____ Fax: (____) _____ - _____

Date first reported to you: _____/_____/_____ Date investigation started: ____/____/____Date form completed: ____/_____/____

(Leave this section blank for state health department use)

Case report reviewed by epidemiologist? ☐ Yes Name: _____ Date reviewed: ___/___/_____

Import Status: ☐ Unk ☐ Acquired in Georgia ☐ Acquired in USA outside GA what state? _____ ☐ Acquired outside USA what country? _____