TEXAS Health and Human Services | Texas Department of State Health Services

For Use by DSHS Central Office Only

Approved By: _____ **Date:** _____

MMWR Year: _____

Leishmaniasis Case Investigation

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

☐ Confirmed

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female ☐ Unknown

Street Address: _____ City, State, Zip: _____

Patient Phone: _____ County of Residence: _____

Race: ☐ Asian ☐ American Indian/Alaskan Native
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Clinical Information

Physician: _____ Address: _____

City, State, Zip: _____ Phone: _____ Fax: _____

Was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, provide name and location of hospital: _____

Dates of hospitalization: Admission ____/____/_____ Discharge ____/____/_____

Date of illness onset: ____/____/_____

Is there a more likely clinical explanation for this patient's symptoms? ☐ Yes ☐ No ☐ Unknown

If yes, provide explanation: _____

Is the patient immunosuppressed? ☐ Yes ☐ No ☐ Unknown

Is the patient deceased? ☐ Yes ☐ No ☐ Unknown

If yes, provide date of death: ____/____/_____ (submit documentation)

Clinical Evidence

Cutaneous leishmaniasis (check all that apply)

Location	# of Lesions	Ulcerative	Nodular	Plaque-like	Other
Face		☐	☐	☐	☐
Neck		☐	☐	☐	☐
Ear		☐	☐	☐	☐
Scalp		☐	☐	☐	☐
Upper arm		☐	☐	☐	☐
Forearm		☐	☐	☐	☐
Hand		☐	☐	☐	☐
Thigh		☐	☐	☐	☐

Other cutaneous features

Satellite lesion ☐ Yes ☐ No ☐ Unknown

Sporotrichoid spread ☐ Yes ☐ No ☐ Unknown

Bacterial superinfection ☐ Yes ☐ No ☐ Unknown

Mucosal leishmaniasis

Lesions located in:

Mouth ☐ Yes ☐ No ☐ Unknown

Nose ☐ Yes ☐ No ☐ Unknown

Throat ☐ Yes ☐ No ☐ Unknown

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Clinical Evidence (Continued)

Cutaneous leishmaniasis (check all that apply)

Location	# of Lesions	Ulcerative	Nodular	Plaque-like	Other
Lower leg		☐	☐	☐	☐
Ankle		☐	☐	☐	☐
Feet		☐	☐	☐	☐
Thorax		☐	☐	☐	☐
Abdomen		☐	☐	☐	☐
Back		☐	☐	☐	☐
Genitals		☐	☐	☐	☐

Visceral leishmaniasis

Fever	☐ Yes	☐ No	☐ Unknown
Splenomegaly	☐ Yes	☐ No	☐ Unknown
Lymphadenopathy	☐ Yes	☐ No	☐ Unknown
Weight loss	☐ Yes	☐ No	☐ Unknown
Hepatomegaly	☐ Yes	☐ No	☐ Unknown

Other, specify: _____

Treatment

Did patient receive treatment? ☐ Yes ☐ No ☐ Unknown

If yes, describe treatment regimen (drug, dosage, administration frequency):

Did patient respond to treatment? ☐ Yes ☐ No ☐ Unknown

Epidemiology

Occupation: _____

(give exact job, type of business or industry, work shift and % of time spent outside while at work)

Did the patient travel to endemic area prior to onset? ☐ Yes ☐ No ☐ Unknown

If yes, provide dates and locations in Travel section *(Visceral – 2 years prior; Cutaneous – 6 mo prior)*

Did patient report bites from small flies or notice small, red, itchy bumps or blisters prior to onset? ☐ Yes ☐ No ☐ Unknown

Prior to onset, did the patient donate or receive blood, blood products, or organ/tissue in the last 30 days? ☐ Yes ☐ No ☐ Unknown

If yes, type of product: ☐ Blood ☐ Blood Product ☐ Organ/Tissue

Donation date: _____/_____/_____ Blood Collection Agency: _____

Transfusion/Transplant date: _____/_____/_____ Medical Facility: _____

Laboratory Findings

Test	Date Collected	Source	Result
	___/___/_____		
	___/___/_____		
	___/___/_____		
	___/___/_____		
	___/___/_____		
	___/___/_____		

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Travel Dates and Locations Prior to Illness Onset				
Dates	**Area/Street Address**	**City**	**State**	**Country**
___/___/_____				
___/___/_____				
___/___/_____				
___/___/_____				

Comments or Other Pertinent Epidemiological Data:

Date First Reported: ____/____/_____ Investigation: Started ____/____/_____ Completed ____/____/_____

Reporting Facility: _____

Name of Investigator: _____ (Please print clearly)

Agency: _____ (Please do not abbreviate)

Phone: _____ E-Mail: _____