Toxoplasmosis Case Report Form

Please fax completed form and laboratory information to Dr. Joni Scheftel at 1-800-233-1817

Demographic & Clinic Information

Demographic Information

Patient's Name: ______________________________

Address: ______________________________

City/ZIP: ______________________________

County: ______________________________

Phone (H): ______________________________

Phone (W): ______________________________

Date of birth: ____ / ____ / ________ Age: ____________

Gender: ☐ Male ☐ Female

Race (check all that apply):

☐ White ☐ Black/African-American

☐ Asian ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Pacific Islander

☐ Unknown ☐ Other: ____________________

Ethnicity:

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Clinic & Clinical Information

Clinician name/specialty: ______________________________

Clinic name: ______________________________

Clinic city: ______________________________

Phone: ______________________________

Person reporting: ______________________________

Was patient hospitalized? ☐ Yes ☐ No

If yes, date of administration: ____ / ____ / ________

Date of discharge: ____ / ____ / ________

Was patient in intensive care? ☐ Yes ☐ No

If yes, date of admission: ____ / ____ / ________

Date of transfer: ____ / ____ / ________

Did the patient die? ☐ Yes ☐ No

If yes, date of death: ____ / ____ / ________

Cause of death: ______________________________

Health History

Case status: ☐ Congenital ☐ Acquired

Date of exam/visit: ____ / ____ / ________

Has the patient been previously diagnosed with toxoplasmosis? ☐ Yes ☐ No

Date of previous episode: ____ / ____ / ________ Describe: ______________________________

Is the patient pregnant? ☐ Yes ☐ No

If yes, EDD: ____ / ____ / ________

Pregnancy outcome:

☐ Live birth

Delivery date: ____ / ____ / ________

☐ Miscarriage/stillbirth

Trimester: ☐ 1st ☐ 2nd ☐ 3rd

Date: ____ / ____ / ________

Is the patient HIV positive: ☐ Yes ☐ No

Is the patient otherwise immunocompromised or on immunosuppressive therapy? ☐ Yes ☐ No

If yes, please describe: ______________________________

Clinic Information

Case classification: ☐ Ocular ☐ Generalized ☐ Cerebral ☐ No symptoms Date of onset: ____ / ____ / ________

Congenital Findings (infant only)

☐ Premature birth

☐ Low birth weight

☐ Jaundice

☐ Macrocephaly

☐ Microcephaly

☐ Microphthalmia

☐ Hydrocephalus

☐ Intracranial calcifications

☐ Hepatosplenomegaly

☐ Hearing loss

☐ Other

Ocular Findings

Is ocular disease:

☐ Bilateral

☐ Unilateral (☐ L ☐ R)

☐ Blurry/hazy vision

☐ Ocular pain

☐ Active Retinitis

☐ Iritis

☐ Optic disc involvement

☐ Uveitis

☐ Retinal scars without reactivation (inactive disease)

☐ Other ocular findings:

____

Other Clinical Findings

☐ Fever

Highest Temp: __________F

☐ Lymphadenopathy

☐ Encephalitis

☐ Seizures

☐ Malaise

☐ Myalgia

☐ Fatigue

☐ Rash

☐ Excessive sweating

☐ Other

Laboratory Information

Please send all laboratory information for the patient along with this form

Specimen collection date	Specimen type (Serum, CSF, etc.)	Type of test	Testing Laboratory name	Reason for testing	Result
		IgG/IgM Toxoplasma antibody ELISA			IgG=__________ IgM=__________
			Palo Alto Medical Foundation (PAMF)	Confirmatory test	

(MDH use only) Interpretation of test results: ☐ False positive ☐ Recently acquired ☐ Infection acquired in the distant past

Diagnostic Imaging

Test: ☐ Cranial CT | Test date: ____ / ____ / ________ ☐ MRI | Test date: ____ / ____ / ________

☐ Radiograph | Test date: ____ / ____ / ________ ☐ Other: _______________ Test date: ____ / ____ / ________

Test findings: ____

Treatment

Has patient been placed on corticosteroid therapy? ☐ Yes ☐ No

If yes, check all that apply:

Corticosteroid	**Date started**	**Dose & duration of treatment**
☐ Prednisone	____ / ____ / ________	___________________________
(☐ Oral ☐ Topical ☐ Other: _______________________)		
☐ Other: _______________________	____ / ____ / ________	___________________________
(☐ Oral ☐ Topical ☐ Other: _______________________)		

Has the patient been place on antibiotic or other therapy (other than cortiocosteroids)? ☐ Yes ☐ No

If yes, check all that apply:

Antibiotic/other therapy	**Date started**	**Dose & duration of treatment**
☐ Pyrimethamine	____ / ____ / ________	___________________________
☐ Sulfadiazine	____ / ____ / ________	___________________________
☐ Folinic Acid (Leucovorin)	____ / ____ / ________	___________________________
☐ Clindamycin	____ / ____ / ________	___________________________
☐ Azithromycin	____ / ____ / ________	___________________________
☐ Atovaquone	____ / ____ / ________	___________________________
☐ Trimethoprim/Sulfamethoxazole (Bactrim)	____ / ____ / ________	___________________________
☐ Spiramycin	____ / ____ / ________	___________________________
☐ Minocycline	____ / ____ / ________	___________________________
☐ Other: _____________________	____ / ____ / ________	___________________________

MDH Minnesota Department *of* Health

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