Division of Emergency Preparedness and Infectious Disease
3 Capitol Hill – Room 106
Providence, RI 02908

# Alpha-gal Syndrome Case Report Form

Use for Alpha-gal syndrome (AGS) case reporting.
Visit https://ndc.services.cdc.gov/ for complete case definition.

To report or request forms:
Office: (401) 222-2577
After hours: (401) 276-8046
Fax: (401) 222-2488
www.health.ri.gov/diseases/for/providers

**Patient Name:** _____ **Date submitted** *(mm/dd/yyyy)*: _____ **CDC#** _____

**Address:** _____ **Healthcare provider's name:** _____

**City:** _____ **Local Patient ID.** *(if reported)*: _____ (Local ID) _____ (Site) _____ (State)

**1. State of residence (postal abbrev.):** _____

**2. County of residence:** _____

**3. Sex:** ◯ Male ◯ Female ◯ Unknown

**4. Patient age (years) at time of case investigation:** _____

**5. Race (check all that apply):**
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other race
- ☐ Unknown
- ☐ Refused

**6. Hispanic or Latino ethnicity:**
- ◯ Yes
- ◯ No
- ◯ Unknown

## CLINICAL CHARACTERISTICS AND OUTCOMES OF AGS

***Enter as much information that is known, with the year (YYYY) at a minimum. For an unknown day or month, that value may be entered as '99'. If no date available, leave blank.***

**7a. Date of most recent AGS reaction that prompted this report** *(mm/dd/yyyy)*: _____

**7b. Has the patient had prior AGS reactions?** ◯ Yes ◯ No ◯ Unknown

**7c. Date of first AGS reaction** *(mm/dd/yyyy)*: _____

**7d. Date of first AGS diagnosis by a healthcare provider** *(mm/dd/yyyy)*: _____

**8. Has the patient ever experienced any of the following signs or symptoms of AGS during a reaction?** *(Check all that apply)*
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Heartburn/indigestion
- ☐ Hives
- ☐ Itching
- ☐ Swelling of lips, tongue, throat, face, eyelids, or other associated structures
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Acute episode of hypotension
- ☐ Other (specify):

**9. Has the patient ever experienced signs or symptoms of an AGS reaction within 2–10 hours after consumption of any of the following?** *(Check all that apply)*
- ☐ Beef
- ☐ Pork
- ☐ Lamb/mutton
- ☐ Goat
- ☐ Game meat (such as venison, boar, bison, elk, rabbit)
- ☐ Milk or milk products (such as cow's milk, cheese, yogurt, butter, ice-cream)
- ☐ Gelatin/glycerin-containing food products (such as gelatin dessert, pudding, gummy candy, marshmallows)
- ☐ Gel-cap medications
- ☐ 'Red meat', not specified
- ☐ Other food product or additive (specify):

**10. Has the patient ever experienced signs or symptoms of an AGS reaction within two hours after receiving any of the following pharmaceutical or medical products intramuscularly, intravenously, or subcutaneously?**
- ☐ Vaccines (specify):
- ☐ Monoclonal antibodies (specify):
- ☐ Anti-venom
- ☐ Heparin
- ☐ Other (specify):

**11. Has the patient ever experienced anaphylaxis due to an AGS reaction** *(involvement of two or more organ systems; including symptoms such as severe difficulty breathing, swelling of tongue or throat, drop in blood pressure or shock as diagnosed by a medical provider)?*
- ◯ Yes
- ◯ No
- ◯ Unknown

**12. Was the patient ever hospitalized because of an AGS reaction?**
- ◯ Yes
- ◯ No
- ◯ Unknown

**If yes, please provide month and year(s):** _____

**13. Did the patient die because of an AGS reaction?**
- ◯ Yes
- ◯ No
- ◯ Unknown

**If yes, date** *(mm/dd/yyyy)*: _____

## TICK BITE HISTORY PRIOR TO AGS ONSET OR DIAGNOSIS

**14. In the 12 months before an AGS reaction or diagnosis (use earlier date), did the patient notice any tick bites?**

◯ Yes ◯ No ◯ Unknown

## LABORATORY

**15. Alpha-gal specific Immunoglobulin-E (alpha-gal sIgE) and total IgE testing**

| Date of specimen collection *(mm/dd/yyyy)* | Testing laboratory | Alpha-gal sIgE quantitative value | Alpha-gal sIgE result | Total IgE quantitative value |
|---|---|---|---|---|
| | | | ◯ Reactive ◯ Nonreactive ◯ Unknown | ◯ Not performed |
| | | | ◯ Reactive ◯ Nonreactive ◯ Unknown | ◯ Not performed |
| | | | ◯ Reactive ◯ Nonreactive ◯ Unknown | ◯ Not performed |
| | | | ◯ Reactive ◯ Nonreactive ◯ Unknown | ◯ Not performed |
| | | | ◯ Reactive ◯ Nonreactive ◯ Unknown | ◯ Not performed |

**16a. Skin prick testing for alpha-gal component reactivity:**

◯ Reactive
◯ Nonreactive
◯ Unknown
◯ Not performed

**16b. Date of test (mm/dd/yyyy):**

_____

***If additional testing performed, please specify in comments.***

**17. Case classification:**

◯ Confirmed ◯ Probable ◯ Suspect ◯ Not a case ◯ Unknown

**State Health Department Official who reviewed this report:**

**Name:** _____ **Phone number:** _____

**Title:** _____ **Email address:** _____

**Date:** _____

**Comments:**



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