NJDOH ALPHA-GAL SYNDROME (AGS) INVESTIGATION WORKSHEET

CDRSS ID: ______________

Return form to the local health department:

Fax: E-mail (secure):

DEMOGRAPHICS

Patient Last Name	First Name	DOB: (mm/dd/yyyy) ___ /___ /_____	Phone number

Address	City	Municipality

Ethnicity
- Hispanic
- Non-Hispanic
- Unknown

Race: (Check all that apply)
- White
- Black or African American
- American Indian/Alaskan Native
- Asian
- Native Hawaiian/Other Pacific Islander
- Other Race
- Unknown
- Refused

Sex:
- Male
- Female
- Unknown

Occupation:

CLINICAL INFORMATION

Date of first AGS reaction:	Date of first AGS diagnosis:	Date of most recent AGS reaction:
___ /___ /_____	___ /___ /_____	___ /___ /_____
If unknown, specify month/year (mm/yyyy)	If unknown, specify month/year (mm/yyyy)	

SIGNS AND SYMPTOMS DURING CURRENT OR ANY PRIOR AGS REACTION

Abdominal pain	Yes	No	Unknown
Anaphlyaxis	Yes	No	Unknown
Cough	Yes	No	Unknown
Diarrhea	Yes	No	Unknown
Facial swelling (lips, tongue, throat, face, eyelids, or associated structures) If yes, describe:	Yes	No	Unknown
Heartburn/indigestion	Yes	No	Unknown
Hives	Yes	No	Unknown
Hypotension, acute episode	Yes	No	Unknown
Nausea	Yes	No	Unknown
Pruritus (itching)	Yes	No	Unknown
Shortness of breath	Yes	No	Unknown
Vomiting	Yes	No	Unknown
Wheezing	Yes	No	Unknown

Other signs/symptoms:

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
- 'Red meat', not specified
- Gel-cap medications
- Game meat
- Milk or milk products *(such as cow's milk, cheese, yogurt, butter, ice-cream)*
- Gelatin/glycerin-containing food products *(gelatin dessert, pudding, gummy candy, marshmallows)*
- Other food products or additives (specify): ____

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
- Anti-venom
- Heparin
- Other (specify): ____

Did a medical provider ever diagnose or tell the patient they had anaphylaxis due to an AGS-associated reaction?

Yes No Unknown

Did the patient die because of an AGS reaction?

- Yes, date: ____ /____ /______
- No
- Unknown

Was the patient ever hospitalized because of an AGS reaction? Yes No Unknown

Was the patient hospitalized related to the current AGS reaction? Yes No Unknown

If yes, Hospital Name: _________________________________ Admission date: ____ /____ /______ Discharge date: ____ /____ /______

RISK FACTORS

In the 12 months before an AGS reaction or diagnosis (use earlier date), did the patient notice any tick bites?	Yes	No	Unknown

LABORATORY TESTING

Alpha-gal specific Immunoglobulin-E (alpha-gal sIgE) 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

Skin prick testing for alpha-gal component reactivity:

Reactive Nonreactive Unknown Not performed

Date of test (mm/dd/yyyy): ____ /____ /______

Additional testing performed:

COMMENTS