

Lyme Disease

PATIENT DEMOGRAPHICS

*NAME (last, first): _____	*Birth date: __/__/____ *Age: _____
*ADDRESS (mailing): _____	*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
*ADDRESS (physical): _____	*Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
*City/State/Zip: _____	*Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. (Mark all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk
*Phone (home): _____ Phone (work/cell): _____	
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
Name: _____ Phone: _____	

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigation Start Date: __/__/____	Case Classification:
Earliest date reported to LHD: __/__/____	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect
Earliest date reported to State: __/__/____	<input type="checkbox"/> Not a case <input type="checkbox"/> Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: Laboratory Hospital HCP Public Health Agency Other

Reporter Name: _____ Reporter Phone: _____

Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __/__/____	Diagnosis date: __/__/____	Recovery date: __/__/____
<p>*CLINICAL FINDINGS</p> <p>Y N U</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diagnosed as Lyme disease by physician</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physician-diagnosed erythema migrans (EM) measuring 5cm or greater in diameter</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cranial neuritis (e.g., Bell's palsy)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Radiculoneuropathy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lymphocytic meningitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Encephalomyelitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Acute onset 2nd or 3rd degree atrioventricular conduction defects that resolve in days to weeks</p>	<p>Hospitalization</p> <p>Y N U</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient hospitalized for this illness</p> <p>Hospital name: _____</p> <p>Admit date: __/__/____ Discharge date: __/__/____</p> <p>Death</p> <p>Y N U</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient died due to this illness If yes, date of death: __/__/____</p>	
	<p>VACCINATION HISTORY</p> <p>Y N U</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Previously received Lyme disease vaccine</p> <p>If yes, date: __/__/____</p> <p>TREATMENT</p> <p>Y N U</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient received antibiotic therapy due to this infection</p> <p>If yes, specify:</p> <p>Type: _____ Duration: _____ days</p>	

LABORATORY (Please submit copies of all labs obtained on this case to DIDE)

Y N U

*Culture positive for *B. burgdorferi*

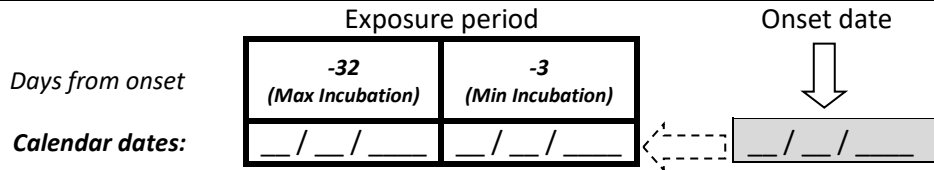
*Serum antibody positive for *B. burgdorferi* by EIA or IFA

*Western immunoblot positive for *B. burgdorferi*-specific IgM (onset ≤30 days)

*Western immunoblot positive for *B. burgdorferi*-specific IgG (at any point during illness)

INFECTION TIMELINE

Instructions: Enter onset date in grey box. Count backward to determine probable exposure period



EPIDEMIOLOGIC EXPOSURES (refer to above exposure period, do not complete this section if no EM is documented)

Y N U

History of travel during exposure period (if yes, complete travel history below):

Destination (City, County, State and Country)	Arrival Date	Departure Date	Reason for travel

Potential occupational exposure (i.e., outdoor work in potential tick habitats)
If yes, list occupation: _____

Where did exposure most likely occur? County: _____ State: _____ Country: _____

PUBLIC HEALTH ISSUES

Y N U

- Case knows someone who had shared exposure and is currently having similar symptoms
- Epi link to another confirmed case of same condition
- Case is part of an outbreak
- Other:

PUBLIC HEALTH ACTIONS

Y N U

- Disease education and prevention information provided to patient and/or family/guardian
- Recommended environmental measures to patient/family to reduce risk around home
- Education or outreach provided to employer
- Facilitate laboratory testing of other symptomatic persons who have a shared exposure
- Patient is lost to follow-up
- Other:

WVEDSS

Y N U

Entered into WVEDSS (Entry date: ___ / ___ / ___) Case Status: Confirmed Probable Suspect Not a case Unknown

NOTES