

# Lyme Disease

Agency: \_\_\_\_\_

Investigator: \_\_\_\_\_

Phone number: \_\_\_\_\_

### FOR STATE USE ONLY

Status:  Confirmed  Probable  
 Suspect  Not a case

Reviewer initials: \_\_\_\_\_

Referred to another state: \_\_\_\_\_

## CASE

Last name: \_\_\_\_\_  
First and middle name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated?  Age: \_\_\_\_\_

Maiden name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Gender:  Female  Male  Other \_\_\_\_\_

Address line: \_\_\_\_\_

Pregnant:  Yes  No  Unk Est. delivery date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Zip: \_\_\_\_\_ City: \_\_\_\_\_

Marital status:  Single  Married  Separated  
 Divorced  Parent with partner  Widowed

State: \_\_\_\_\_ County: \_\_\_\_\_

Race:  American Indian or Alaskan Native  Unknown  
 Black or African American  White  
 Hawaiian or Pacific Islander  Asian

Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Long-term care resident:  Yes  No  Unknown

Parent/Guardian name: \_\_\_\_\_

Facility name: \_\_\_\_\_

Parent/Guardian phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

## EVENT

Diagnosis date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Last name: \_\_\_\_\_

Event outcome:  Survived this illness  Died from this illness  
 Died unrelated to this illness  Unknown

First name: \_\_\_\_\_

Outbreak related:  Yes  No  Unknown

Provider title:  ARNP  MD  
 DO  NP  PA

Outbreak name: \_\_\_\_\_

Facility name: \_\_\_\_\_

Exposure setting: \_\_\_\_\_

Address line 1: \_\_\_\_\_

Epi-linked:  Yes  No  Unknown

Address line 2: \_\_\_\_\_

Location acquired:  In USA, in reporting state  
 In USA, outside reporting state  
 Outside USA  
 Unknown

Zip code: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Country: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_

Phone : (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Healthcare provider information

## LABORATORY FINDINGS

Laboratory: \_\_\_\_\_ Accession #: \_\_\_\_\_ Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Specimen source: \_\_\_\_\_ Test type: \_\_\_\_\_

Result type:  Preliminary  Final Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result:  Positive  Negative

Organism: ***Borrelia burgdorferi***

Laboratory: \_\_\_\_\_ Accession #: \_\_\_\_\_ Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Specimen source: \_\_\_\_\_ Test type: \_\_\_\_\_

Result type:  Preliminary  Final Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result:  Positive  Negative

Organism: ***Borrelia burgdorferi***

Laboratory: \_\_\_\_\_ Accession #: \_\_\_\_\_ Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Specimen source: \_\_\_\_\_ Test type: \_\_\_\_\_

Result type:  Preliminary  Final

Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Result:  Positive  Negative

Organism: **Borrelia burgdorferi**

**OCCUPATIONS**

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____)____-____-____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____)____-____-____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**HOSPITALIZATIONS**

Was the case hospitalized?  Yes  No  Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

**CLINICAL INFO & DIAGNOSIS**

Fever:  Yes  No  Unk Onset Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Duration (days): \_\_\_\_\_ Highest known fever: \_\_\_\_\_ °F/C

- |  |   |
|--|---|
| <b>Other symptoms:</b> <input type="checkbox"/> Arthralgia | <b>Life threatening complications:</b> <input type="checkbox"/> Adult respiratory distress syndrome |
| <input type="checkbox"/> Fatigue                           | <input type="checkbox"/> Disseminated intravascular coagulopathy                                    |
| <input type="checkbox"/> Headache                          | <input type="checkbox"/> Meningitis/Encephalitis  |
| <input type="checkbox"/> Mild, stiff neck                  | <input type="checkbox"/> Renal failure  |
| <input type="checkbox"/> Muscle pain                       |   |

Did the health care provider for the case diagnose Lyme disease?  Yes  No  Unk

Erythema migrans diagnosed by physician present:  Yes  No  Unk Onset Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Lesion greater than or equal to 5 cm:  Yes  No  Unk

- |  |   |
|--|---|
| <b>Late manifestations:</b> <input type="checkbox"/> 2 <sup>nd</sup> /3 <sup>rd</sup> degree atrioventricular (AV) block | <input type="checkbox"/> Recurrent, brief attacks of joint swelling |
| <input type="checkbox"/> Facial palsy  | <input type="checkbox"/> Lymphocytic meningitis                     |
| <input type="checkbox"/> Encephalitis/Encephalomyelitis  | <input type="checkbox"/> Radiculoneuropathy                         |
| <input type="checkbox"/> Cranial neuritis  |   |

**OTHER LAB FINDINGS**



