Lyme Disease Confidential Case Report

Physician Name: _____Physician Phone#:_____ *Fax:*_____

Name of Reporting Facility: _____

Patient Last Name_____ First Name_____ Telephone #_____

Address_____ City/Town/Village_____ Zip_____

Date of Birth: _____ Gender: Male Female Pregnant: Yes No Unknown

Race: White___ Black___ American Indian___ Asian___ Native Hawaiian/Pacific Islander___ Other___ Unknown ___

Ethnicity: Hispanic___ Not Hispanic___ Unknown___

CLINICAL

Please circle responses next to patient's symptoms as appropriate

Has a physician diagnosed this patient with Lyme disease?.....	***Yes***	***No***	***Unknown***
Erythema migrans > 5cm (MD diagnosed).....	***Yes***	***No***	***Unknown***
Arthritis with observed objective joint swelling.....	***Yes***	***No***	***Unknown***
Arthritis without observed objective joint swelling.....	***Yes***	***No***	***Unknown***
Cranial neuritis including Bell's Palsy.....	***Yes***	***No***	***Unknown***
Lymphocytic Meningitis.....	***Yes***	***No***	***Unknown***
Radiculoneuropathy.....	***Yes***	***No***	***Unknown***
Encephalomyelitis and antibody to *B. burgdorferi* higher in CSF than in serum	***Yes***	***No***	***Unknown***
Acute Secondary or Tertiary A-V Block	***Yes***	***No***	***Unknown***

Other Symptoms_____

Date of first symptom: _____ Date of diagnosis: _____ ICD 9 codes used: _____

Hospitalized? Yes No Unknown Name of Hospital: _____ Admission/Discharge Date: _____

Treatment: _____ Date Initiated: ____/____/_____ Duration: _____

Tick Bite: Yes No If yes, species: _____ Date of Bite: ____/____/_____

Has the patient been tested for other tick-borne infections: Yes No Hx of Babesiosis Yes No Unknown Date of Diagnosis: ___/___/___

Hx of Anaplasmosis Yes No Unknown Date of Diagnosis: ___/___/___

LABORATORY RESULTS – Date: _____

ELISA/EIA/IFA	Total AB (IgG &	Pos	Neg	Equiv	Unk	Not Done
	IgM Ab	Pos	Neg	Equiv	Unk	Not Done
WESTERN BLOT	IgG blot	Pos	Neg	Equiv	Unk	Not Done
	IgM blot	Pos	Neg	Equiv	Unk	Not Done

Name of person completing form: _____ Date: ___/___/_____

PLEASE RETURN THIS FORM TO: ORANGE COUNTY DEPARTMENT OF HEALTH 124 MAIN STREET GOSHEN, NY 10924
CALL (845) 615-3884 OR FAX TO (845) 291-2341

Reviewed 8/13