# 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

Race:

- ☐ White
- ☐ Black/African American
- ☐ American Indian or Alaska native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other, specify: _____
- ☐ Unknown

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ 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_____ Pregnant? Yes No Unknown Hospitalized? Yes No Unknown

Date of first symptom: _____ Date of diagnosis:_____ Admission Date:_____

Name of Hospital:_____ Treatment:_____

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

Has the patient been tested for other tick-borne infections: Yes No If yes, which:_____ Date of Diagnosis: ___/___/___

LABORATORY RESULTS – please circle

| | | | | | | |
|---|---|---|---|---|---|---|
| **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 |

**OTHER**_____ Report Date_____

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

**PLEASE RETURN THIS FORM TO: ORANGE COUNTY DEPARTMENT OF HEALTH 124 MAIN STREET GOSHEN, NY 10924**
**CALL (845) 615-3886 OR FAX TO (845) 291-2341**

*6/2/08*