**Maine Center for Disease Control and Prevention**

**Lyme Disease Case Report Form**

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| --- |
| **Patient Information** |
| Last Name: |       | First Name: |       |  |
| Street Address: |       |  |
| City: |       | State: |       | Zip: |       |  |  |
| Date of Birth: |      /     /      | Gender: | [ ]  Male [ ] Female |  |
| Race: | [ ]  White [ ]  Black [ ]  Amer. Indian/Eskimo [ ]  Asian/Pacific Islander [ ] Unknown |  |
| Ethnicity: | [ ]  Hispanic [ ] Non-Hispanic |  |
| Occupation: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Symptoms and Signs of Current Episode: Please Answer Each Question** |
|  |  | Yes | No | Unk |  |
| Dermatologic: | Erythema migrans (physician diagnosed EM at least 5cm in diameter).. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
| Rheumatologic: | Arthritis characterized by brief attacks of joint swelling.. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
| Neurologic: | Bell’s palsy or other cranial neuritis. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
|  | Radiculoneuropathy.. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
|  | Lymphocytic meningitis.. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
|  | Encephalitis/Encephalomyelitis.. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
|  | CSF tested for antibodies to *B. burgdorferi* .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
|  | Antibody to *B. burgdorferi* higher in CSF than serum .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
| Cardiologic: | 2nd or 3rd degree atrioventricular block.. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. . | [ ]  | [ ]  | [ ]  |  |
|  |  |  |  |  |
| Date of Onset of First Symptoms: |      /     /      | Date of Diagnosis: |      /     /      |  |
| Patient diagnosed with Lyme disease in the past? | [ ]  Yes [ ] No [ ] Unk | If yes, month/year: |  / |  |
|  |
| Patient tested for other tickborne diseases? | [ ]  Yes [ ] No [ ] Unk | If yes, which one(s): [ ] Anaplasmosis [ ] Babesiosis |  |
|  [ ] Ehrlichiosis [ ]  RMSF [ ] Tularemia |
| Was the patient hospitalized? | [ ]  Yes [ ] No [ ] Unk | If yes, hospital: |       |  |
| Pregnant at time of diagnosis? | [ ]  Yes [ ] No [ ] Unk |  |  |  |
| **Exposure Information** |  |
| Where was the patient exposed? | Town: |       | County: |       | State: |       |  |
| History of Tick Bite?  | [ ]  Yes [ ] No [ ] Unk |  |
| **Laboratory Findings** |
| * Please send a copy of all Lyme disease testing.
* Without laboratory report, form will be incomplete and not counted, except when Erythema migrans is present.
 |  |
| **Diagnosis (Please Check One Option)** |
|  | [ ]  Yes, this patient has been diagnosed with Lyme disease. |  |
|  | [ ]  This patient is still undergoing evaluation. Please contact me again in [ ] 15 [ ] 30 [ ] 60 days. |  |
|  | [ ]  I do not believe this patient has Lyme disease. |  |
|  | [ ]  Please contact the following health care provider to obtain information about this patient: |  |
|  | Other Provider’s Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Provider/Reporter Information** |
| Provider’s Name: |       | Telephone Number: |       |  |
| Address: |       | City: |  | State: |       |  |
|  |  |  |  |  |
| Date Sent by Maine CDC: |  / / | Date Returned: |  / / |  |

Reviewed 5/2014 **Maine CDC Fax: 1-207-287-6865**