Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

Lyme Disease

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	"Bulls-eye" rash
☐	☐	☐	☐	Fever Highest measured temp: _____ °F
				Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Stiff neck
☐	☐	☐	☐	Fatigue
☐	☐	☐	☐	Muscle aches or pain (myalgia)
☐	☐	☐	☐	**Recurrent arthritis**
☐	☐	☐	☐	Other symptoms consistent with illness
				Specify: _____

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Pregnant
				Estimated delivery date ___/___/___
				OB name, address, phone: _____
				_____

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	**Erythema migrans => 5 cm in diameter diagnosed by a health care provider**
☐	☐	☐	☐	**High-grade atrioventricular block (secondary or tertiary)**
☐	☐	☐	☐	**Cranial neuritis or Bell's palsy**
☐	☐	☐	☐	**Encephalitis or encephalomyelitis**
☐	☐	☐	☐	**Lymphocytic meningitis**
☐	☐	☐	☐	**Myocarditis**
☐	☐	☐	☐	**Radiculoneuropathy**
☐	☐	☐	☐	Regional lymphadenitis
☐	☐	☐	☐	Meningitis

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	***Borrelia burgdorferi*** **isolation (clinical specimen)**
☐	☐	☐	☐	**Diagnostic IgM or IgG antibodies to *B. burgdorferi* by EIA or IFA (serum, CSF)**
☐	☐	☐	☐	**CSF IgM or IgG titer by EIA or IFA higher than serum titer (serum and CSF)**
☐	☐	☐	☐	**Lyme disease confirmed by Western blot**

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

	Exposure period		onset
Days from onset:	-32	-3	
Calendar dates:			

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
_____
_____

Y N DK NA

☐ ☐ ☐ ☐ Insect or tick bite
☐ Deer fly ☐ Flea ☐ Mosquito ☐ Tick
☐ Louse ☐ Other: _____ ☐ Unk
Location of insect or tick exposure
☐ WA county ☐ Other state ☐ Other country
☐ Multiple exposures ☐ Unk
Date of exposure: ___/___/___

☐ ☐ ☐ ☐ Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS/TREATMENT

Y N DK NA

☐ ☐ ☐ ☐ Antibiotics prescribed for this illness Name: _____
Date antibiotic treatment began: ___/___/___ # days antibiotic actually taken: _____

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Any, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____