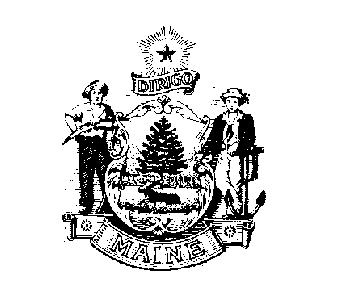
**Maine Center for Disease Control and Prevention**



**Lyme Disease Case Report Form**

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