



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).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatologic: Arthritis characterized by brief attacks of joint swelling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic: Bell's palsy or other cranial neuritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiculoneuropathy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphocytic meningitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis/Encephalomyelitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSF tested for antibodies to <i>B. burgdorferi</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibody to <i>B. burgdorferi</i> higher in CSF than serum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiologic: 2 nd or 3 rd degree atrioventricular block.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: ____/____/____