

Lyme Disease Case Report Form

Michigan Department of Community Health

Communicable Disease and Immunization Division

Investigation Information				
Investigation ID	Part of an outbreak? <i>Yes No Unknown</i>	Outbreak Name	Referral Date <small>mm/dd/yyyy</small>	
Investigation Status <i>New Active Completed Superseded Cancelled</i>		Case Status <i>Confirmed Not a Case Probable Suspect Unknown</i>		
Patient Status <i>Inpatient Outpatient Died</i>		Patient Status Date <small>mm/dd/yyyy</small>	Diagnosis Date <small>mm/dd/yyyy</small>	Onset Date <small>mm/dd/yyyy</small>
Patient Information				
Patient ID	First	Last	Middle	
Street Address				
City	County	State		Zip
Home Phone <small>###-###-####</small>		Ext.	Other Phone <small>###-###-####</small>	
Parent/Guardian (required if under 18)				
First		Last	Middle	
Demographics				
Sex <i>Male Female Unknown</i>		Date of Birth <small>mm/dd/yyyy</small>	Age	Age Units <i>Days Months Years</i>
Race <i>Caucasian African American American Indian/Alaska Native Hawaiian/Pacific Islander</i> <i>Asian Unknown Other (Specify) _____</i>				
Ethnicity <i>Hispanic/Latino Non-Hispanic/Latino Unknown</i>			Worksites/School	Occupations/Grade
Referral Information				
Person Providing Referral				
First	Last	Phone <small>###-###-####</small>	Ext.	Email
Primary Physician				
First	Last	Phone <small>###-###-####</small>	Ext.	Email
Street Address				
City	County	State		Zip

Clinical Information

Symptoms and Signs of Current Episode

Clinical Characteristics	Present?
	Y=Yes N=No UNK=Unknown
Erythema migrans (physician diagnosed EM at least 5 cm or about 2 inches in diameter)?	
Arthritis characterized by brief attacks of joint swelling?	
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?	
2nd or 3rd degree atrioventricular block?	

Other Clinical Information:

Was the patient hospitalized for the current episode? <i>Yes No Unknown</i>	Name of antibiotic(s) used during this episode?	Number of Days used?
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Was the patient pregnant at the time of illness?

Yes No Unknown

Where was the patient most likely exposed?

County:	State:
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Laboratory Information

Test Name/Test Method	Test Result
	P=Positive N=Negative E=Equivocal ND=Not Done UNK=Unknown
Culture	
EIA	
IFA	
Western Blot IgM	
Western Blot IgG	
C6 peptide	
Other	

If Other, please specify:

Other Information

Local 1		Local 2		
Name of Person interviewed		Relationship to patient		Date of interview mm/dd/yyyy
Submitted by:	Date mm/dd/yyyy	Health Department	Phone Number ###-###-####	Ext.

Comments or Additional Information