

Lyme Disease Case Investigation

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

Patient Information

Last Name: _____ First Name: _____
 Date of Birth: ____/____/____ Age: _____ Sex: Male Female Unknown
 Street Address: _____ City, State, Zip: _____
 Patient Phone: _____ County of Residence: _____
 Race: Asian American Indian/Alaskan Native
 Black or African American Native Hawaiian/Pacific Islander
 White Unknown Other: _____
 Ethnicity: Hispanic Not Hispanic Unknown

Clinical Information

Physician: _____ Address: _____
 City, State, Zip: _____ Phone: _____ Fax: _____
 Did the healthcare provider diagnose the patient with LD? Yes No Unknown
 Date of LD Diagnosis: ____/____/____
 Was the patient hospitalized for this illness? Yes No Unknown
 If yes, provide name and location of hospital: _____
 Dates of hospitalization: Admission ____/____/____ Discharge ____/____/____
 Date of Symptom Onset: ____/____/____
 Is there a more likely clinical explanation for this patient's symptoms? Yes No Unknown
 If yes, provide explanation: _____
 Was the patient pregnant during illness? Yes No Unknown N/A
 If yes, provide week of pregnancy: _____ Outcome of pregnancy? _____
 Is the patient deceased? Yes No Unknown
 If yes, provide date of death: ____/____/____ (submit documentation)

Clinical Evidence (check all that apply)

Case definition clinical evidence

Erythema Migrans (EM) Yes No Unknown
 (≥5cm, observed by health care provider)
 Arthritis Yes No Unknown
 Bell's palsy Yes No Unknown
 Radiculoneuropathy Yes No Unknown
 Lymphocytic meningitis Yes No Unknown
 Encephalomyelitis Yes No Unknown
 2nd or 3rd degree heart block Yes No Unknown

Other signs and symptoms

Arthralgia Palpitations
 Bundle Branch Block Peripheral neuropathy
 Cognitive impairment Myalgia
 Encephalopathy Fatigue
 Fever/Sweats/Chills Neck pain
 Headache Myocarditis
 Paresthesias Other rash
 Visual/auditory impairment Other: _____

Laboratory Findings

Initial Lyme disease antibody screening test (Tier 1):

EIA/IFA (IgM and/or IgG): Positive Negative Equivocal Not Done Collect Date: ____/____/____

Immunoblot confirmatory test (Tier 2):

IgM: Positive Negative Not Done Collect Date: ____/____/____

IgG: Positive Negative Not Done Collect Date: ____/____/____

Culture/Other Test: _____

Treatment

Did patient receive antibiotic treatment? Yes No Unknown Start Date: ____/____/____
If yes, indicate antibiotics used for this illness (check all that apply):
 Doxycycline Ceftriaxone Penicillin Amoxicillin
 Azithromycin Cefuroxime axetil Unknown Other: _____
Combined duration of antibiotics for this illness: <1 month 1-3 months >3 months unknown
Did patient respond to treatment? Yes No Unknown

Epidemiology

Prior to symptom onset (at most 30 days prior for IgM positive Immunoblots; more than a month prior for IgG positive immunoblots):

Was this patient in wooded, brushy or grassy areas?
Within Texas: Yes No Unknown Texas **County** of exposure: _____
Outside of Texas: Yes No Unknown Outside **State/County** of exposure: _____
Did the patient report cave exploration (i.e. caving or spelunking)? Yes No Unknown
Did patient travel outside county of residence? Yes No Unknown
Did the patient previously live in a high incidence state or country for Lyme disease? Yes No Unknown

Provide travel dates and locations below.

Travel Dates and Locations Prior to Illness Onset

Dates	Area/Street Address	City	State	Country
____/____/____				
____/____/____				
____/____/____				

Comments or Other Pertinent Epidemiological Data:

Case Classification

<input type="checkbox"/> Confirmed <input type="checkbox"/> Physician diagnosed EM ≥ 5 cm with exposure in a high-incidence state or country* for Lyme disease <input type="checkbox"/> Physician diagnosed EM ≥ 5 cm with potential exposure in a low-incidence state or country* OR a physician-diagnosed late manifestation, with the following laboratory evidence of infection: <input type="checkbox"/> Two-tier IgM Immunoblot**, OR <input type="checkbox"/> IgG Immunoblot, OR <input type="checkbox"/> Culture positive for <i>B. burgdorferi</i> Please include documentation of EM rash, late manifestation(s), and/or any Lyme disease test results that were not uploaded to NBS.	<input type="checkbox"/> Probable <input type="checkbox"/> Any other case of physician diagnosed Lyme disease with non-confirmatory, but clinically compatible, symptoms with the following laboratory evidence of infection and the absence of a more likely clinical explanation: <input type="checkbox"/> Two-tier IgM Immunoblot**, OR <input type="checkbox"/> IgG Immunoblot, OR <input type="checkbox"/> Culture positive for <i>B. burgdorferi</i>	<input type="checkbox"/> Suspect <input type="checkbox"/> EM with no known exposure and no laboratory evidence of infection, OR <input type="checkbox"/> Laboratory evidence of infection, but no clinical information available <input type="checkbox"/> Not A Case <input type="checkbox"/> Physician diagnosed EM of <5 cm without supporting lab results, OR <input type="checkbox"/> A positive or equivocal EIA/IFA result only, OR <input type="checkbox"/> A positive IgM Western Blot only, OR <input type="checkbox"/> Physician specifically states this is not a case of Lyme disease
--	---	--

*An exposure in a high-incidence state is defined as exposure in a state with an average Lyme disease incidence of at least 10 confirmed cases/100,000 for the previous three reporting years. A low-incidence state is defined as a state with disease incidence of <10 confirmed cases/100,000. Texas is considered a low-incidence state for Lyme disease.
**Positive IgM Immunoblot is sufficient only when used in conjunction with IFA/EIA (tier 1) test and when collected ≤30 days after symptom onset.

Date First Reported: ____/____/____ Investigation: Started ____/____/____ Completed ____/____/____
Reporting Facility: _____
Name of Investigator: _____ (Please print clearly)
Agency: _____ (Please do not abbreviate)
Phone: _____ E-Mail: _____