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| **NJDOH LYME DISEASE CASE INVESTIGATION FORM** | | | | | | **CDRSS #:** **Click here to enter text.** | | | |
| **PATIENT INFORMATION** | | | | | | | | | |
| **Name:** Click here to enter FIRST AND LAST NAME. | | | | | **Birth Date:** Click here, use arrow (right) to select date. | | | | |
| **Phone Number:** XXX-XXX-XXXX | | | | | **Address:**  Click here to enter ADDRESS. | | | | |
| **Ethnicity:**  Hispanic  Non-Hispanic | **Race:**  White Black  Native Hawaiian/Pacific Islander  Asian American Indian or Alaskan Native | | | |
| **CLINICAL INFORMATION** | | | | | | | | | |
| **Has the clinician diagnosed this patient with Lyme disease?**  Yes **🡪 Date:** Click here, use arrow (right) to select date.  No  *(Definition of diagnosis for NJDOH surveillance purposes may include clinical findings, laboratory results, or diagnosis of exclusion)* | | | | **Symptom Onset Date:** Click here, use arrow (right) to select date. | | | | | |
| **If exact onset date is unknown, did symptoms develop greater than 30 days before specimen collection?** | | | | | Yes  No |
| **­SIGNS OR SYMPTOMS (NOT EXPLAINED BY ANOTHER ETIOLOGY):** | | | | | | | | | |
| *Rash*  *Erythema migrans (EM) rash > 5 cm* | | *Musculoskeletal*  *Recurrent, brief attacks*  *(weeks or months) of objective joint swelling in one or a few joints, sometimes followed by chronic arthritis in one or a few joints* | | *Neurologic*  *Lymphocytic meningitis*  *Cranial neuritis*  *Facial palsy*  *Radiculoneuropathy*  *Encephalomyelitis* | | | | *Cardiac*  *Acute onset of high-grade (2nd or 3rd-degree) atrioventricular conduction defects that resolve in days to weeks and are sometimes*  *associated with myocarditis* | |
| **Additional Signs / Symptoms:**  Click here to enter text. | | | | | | | | | |
| **RISK FACTORS** | | | | | | | | | |
| **Was there exposure to tick infested areas?**  Yes **🡪** **Date:** Click here, use arrow (right) to select date.  No  Unknown | | | | **Did the patient have a recent tick bite?**  Yes **🡪 Date:** Click here, use arrow (right) to select date.  No  Unknown | | | | | |
| **TREATMENT** | | | | | | | | | |
| **Name of Antibiotic(s)** | | | **Dosage and Duration** | | | | **Dates of Treatment** | | |
| Name of antibiotic 1. | | | Click here to enter text. | | | | Pick Date. **TO** Pick Date. | | |
| Name of antibiotic 2. | | | Click here to enter text. | | | | Pick Date. **TO** Pick Date. | | |
| Not Treated | | | | | | | | | |
| **ADDITIONAL COMMENTS** | | | | | | | | | |
| Click here to enter text. | | | | | | | | | |

**RETURN COMPLETED FORM BY FAX TO:** XXX-XXX-XXXX **ATTENTION:**  Name (first and last)