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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)