

NJDOH EHRLICHIOSIS / ANAPLASMOSIS INVESTIGATION WORKSHEET

MR #: _____

CDRSS #: _____

DEMOGRAPHICS

Patient Last Name		First Name		DOB: ____ / ____ / ____	Phone number
Address				City	Municipality
Race White Black Asian Pacific Islander			American Indian or Alaskan Native Unknown		
Ethnicity Hispanic Non-Hispanic			Unknown		
Gender	Industry (work setting)		Occupation (job title)		
Indicate Disease Investigated				Pregnancy status	
Anaplasmosis - <i>Anaplasma phagocytophilum</i>		Ehrlichiosis - <i>Ehrlichia chaffeensis</i>		Pregnant	
Ehrlichiosis/Anaplasmosis - Undetermined		Ehrlichiosis - <i>Ehrlichia ewingii</i>		Not pregnant	
				N/A	
				Unknown	

CLINICAL INFORMATION

Date first seen by a medical professional ____ / ____ / ____	Onset Date ____ / ____ / ____	Diagnosis:
Signs/Symptoms	Response	Onset Date
Acute respiratory distress syndrome (ARDS)	Yes No Unk.	____ / ____ / ____
Anemia	Yes No Unk.	____ / ____ / ____
Asymptomatic	Yes No Unk.	____ / ____ / ____
Chills	Yes No Unk.	____ / ____ / ____
Disseminated Intravascular coagulation (DIC)	Yes No Unk.	____ / ____ / ____
Elevated liver enzymes	Yes No Unk.	____ / ____ / ____
Encephalitis	Yes No Unk.	____ / ____ / ____
Fever, Tmax _____ F	Yes No Unk.	____ / ____ / ____
Headache	Yes No Unk.	____ / ____ / ____
Jaundice	Yes No Unk.	____ / ____ / ____
Leukopenia	Yes No Unk.	____ / ____ / ____
Meningitis	Yes No Unk.	____ / ____ / ____
Myalgia	Yes No Unk.	____ / ____ / ____
Organ failure <i>specify:</i>	Yes No Unk.	____ / ____ / ____
Rash	Yes No Unk.	____ / ____ / ____
Thrombocytopenia	Yes No Unk.	____ / ____ / ____
Vomiting	Yes No Unk.	____ / ____ / ____
Other <i>specify:</i>		____ / ____ / ____
Other <i>specify:</i>		____ / ____ / ____
Other <i>specify:</i>		____ / ____ / ____

Did the patient experience any severe complications of the following in the clinical course of illness: acute respiratory distress syndrome, disseminated intravascular coagulation, meningitis, encephalitis, or organ failure?

Yes, specify _____

No

Unknown

Was an underlying immunosuppressive condition present?

Yes, specify _____

No

Unknown

Was patient hospitalized because of this illness?

Yes, specify location and date(s)

Hospital name: _____

Admission: ____ / ____ / ____ Discharge: ____ / ____ / ____

Diagnosis: _____

No

Did the patient die because of this illness?

Yes, specify date ____ / ____ / ____

No

Unknown

In the 30 days prior to illness onset or diagnosis, did the patient donate blood?

Yes, Date of blood donation: _____

No

Unknown

Location of blood donation: _____

TREATMENT INFORMATION

Treatment	Dosage	Dates
Doxycycline		____ / ____ / ____ to ____ / ____ / ____
Rifampin		____ / ____ / ____ to ____ / ____ / ____
Other: _____		____ / ____ / ____ to ____ / ____ / ____
Not treated		

RISK FACTORS

Risk factor	Response		
In the 14 days prior to illness onset/diagnosis, did the patient spend time outdoors in grassy or wooded areas?	Yes	No	Unk.
In the 14 days prior to illness onset/diagnosis, did the patient notice a tick bite? If yes, specify location of tick bite: Date of tick bite: ____ / ____ / ____	Yes	No	Unk.
In the year days prior to illness onset/diagnosis, did the patient receive a blood transfusion? If yes, provide a list of transfusion date(s), hospital where transfused, type of blood product(s), and source of blood products:	Yes	No	Unk.
In the year prior to illness onset/diagnosis, did the patient receive an organ transplant? If yes, list type of organ, date, hospital:	Yes	No	Unk.

ADDITIONAL CASE NOTES
