NJDOH ANAPLASMOSIS INVESTIGATION WORKSHEET

MR #: _____ **CDRSS #:** _____

DEMOGRAPHICS

Patient Last Name	**First Name**	**DOB:**	**Phone number**
		____ / ____ / ____	

Address	**City**	**Municipality**

Race

☐ White ☐ Black ☐ American Indian or Alaskan Native
☐ Asian ☐ Pacific Islander ☐ Unknown

Ethnicity

☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Sex	**Industry (work setting)**	**Occupation (job title)**

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 c-reactive protein	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Elevated liver enzymes	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Encephalitis	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Fatigue	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Fever, Tmax _____F	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Headache	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Leukopenia	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Malaise	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Meningitis	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Myalgia	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Organ failure *specify:*	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Sweats	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Thrombocytopenia	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Other *specify*:		____ / ____ / ____

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

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 center: _____

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

TREATMENT INFORMATION

Including any medication to be continued outpatient, if hospitalized

Treatment	Dosage	Dates
☐ Doxycycline		_____ / _____ / _____ to _____ / _____ / _____
☐ Other: _____		_____ / _____ / _____ to _____ / _____ / _____
☐ Other: _____		_____ / _____ / _____ to _____ / _____ / _____
☐ Not treated		

RISK FACTORS

Risk factor	Response
In the year 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 of transplant, and transplant facility:*	◯ 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 if outside NJ:* *Date of tick bite:* _____ / _____ / _____	◯ Yes ◯ No ◯ Unk.
In the 30 days before illness onset or diagnosis, did the patient donate an organ? *If yes, list type of organ, date of donation, and donation facility:*	◯ Yes ◯ No ◯ Unk.
In the 14 days prior to illness onset/diagnosis, did the patient spend time outdoors in grassy or wooded areas?	◯ Yes ◯ No ◯ Unk.

ADDITIONAL CASE NOTES