NJDOH *Borrelia miyamotoi* Infection Case Report Form **CDRSS #:**

PATIENT DEMOGRAPHIC INFORMATION

Last Name	First Name	Middle Initial	Date of Birth	Gender
			____/ ____/____	◯Female ◯Male ◯Unknown

Address:	City	State	Zip Code	Telephone Number
				( ) -

Ethnicity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Race:
☐ Asian ☐ Black/African American ☐ American Indian/ Alaskan Native
☐ White ☐ Unknown ☐ Native Hawaiian/Pacific Islander

SYMPTOM INFORMATION

Symptom Onset Date:	Diagnosis Date:	Provider Diagnosis:
___/___/___	___/___/___	

Fever: ◯Yes ◯No ◯Unknown
If "Yes", what was highest temperature? °F/°C
If "Yes", was fever relapsing? ◯Yes ◯No ◯Unknown

LHD NOTE: If the HCP is unable to provide information about whether there was a history of fever, please contact the patient.

Headache:	◯Yes	◯No	◯Unknown	Abdominal pain:	◯Yes	◯No	◯Unknown
Chills:	◯Yes	◯No	◯Unknown	Anorexia:	◯Yes	◯No	◯Unknown
Night sweats:	◯Yes	◯No	◯Unknown	Dyspnea:	◯Yes	◯No	◯Unknown
Myalgia:	◯Yes	◯No	◯Unknown	Erythema migrans rash:	◯Yes	◯No	◯Unknown
Arthralgia:	◯Yes	◯No	◯Unknown	Dizziness:	◯Yes	◯No	◯Unknown
Fatigue:	◯Yes	◯No	◯Unknown	Confusion:	◯Yes	◯No	◯Unknown
Nausea:	◯Yes	◯No	◯Unknown	Photophobia:	◯Yes	◯No	◯Unknown
Vomiting:	◯Yes	◯No	◯Unknown	Vertigo:	◯Yes	◯No	◯Unknown
Diarrhea:	◯Yes	◯No	◯Unknown	Meningoencephalitis:	◯Yes	◯No	◯Unknown

Other symptoms (please describe):

CLINICAL INFORMATION

Leukopenia:	◯Yes	◯No	◯Unknown	Thrombocytopenia:	◯Yes	◯No	◯Unknown
Neutropenia:	◯Yes	◯No	◯Unknown	Elevated liver enzyme levels:	◯Yes	◯No	◯Unknown

Does the patient have any underlying immunosuppressive illnesses? ◯Yes ◯No ◯Unknown

If "Yes", please describe:

Did patient die from their illness?	◯Yes	◯No	◯Unknown	Was patient hospitalized?	◯Yes	◯No	◯Unknown

Hospital Name:	Admit Date:	Discharge Date:

DIAGNOSTIC LABORATORY INFORMATION

Please send a copy of any laboratory results, including co-infections, to NJDOH along with this completed case report form

Borrelia mayonii	◯Positive	◯Negative	◯Not Done	Ehrlichiosis	◯Positive	◯Negative	◯Not Done
Anaplasmosis	◯Positive	◯Negative	◯Not Done	Lyme Disease	◯Positive	◯Negative	◯Not Done
Babesia	◯Positive	◯Negative	◯Not Done	Other:	◯Positive	◯Negative	◯Not Done

TREATMENT

Name of Antibiotic(s)	Dosage and Duration	Dates of Treatment
☐ Doxycycline		___/___/___ to ___/___/___
☐ Other antibiotic		___/___/___ to ___/___/___
☐ Not treated		

EXPOSURE INFORMATION	
In the 30 days before the illness onset date, did the patient:	
Have a history of a tick bite? ◯ Yes ◯ No ◯ Unknown	Travel outside of New Jersey? ◯ Yes ◯ No ◯ Unknown
If "Yes", date of bite:	If "Yes", dates of travel: ___/____/____ to___/____/____
If "Yes", town where bite occurred:	If "Yes", travel location(s):

ADDITIONAL COMMENTS

PROVIDER INFORMATION	
Provider Name	Telephone Number ( ) -
Provider Address	Fax Number ( ) -

Please fax completed case report form to the New Jersey Department of Health at: **(609)- 826-4874**