New Jersey Department of Health

BABESIOSIS REPORT

Date	CDRSS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race
☐ White ☐ American Indian ☐ Unknown/Other
☐ Black ☐ Asian

Ethnicity
☐ Hispanic ☐ Unknown
☐ Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospitalized? ☐ Yes ☐ No	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	☐ Yes ☐ No ☐ Unknown	☐ Probable ☐ Confirmed

Clinical:

Fever? ☐ Yes ☐ No Highest temp.: _____ Thrombocytopenia? ☐ Yes ☐ No
Chills? ☐ Yes ☐ No Anemia? ☐ Yes ☐ No
Headache? ☐ Yes ☐ No Myalgia? ☐ Yes ☐ No
Other symptoms: _____

Risk Factors:

Tick exposure (within last 2 months)? ☐ Yes ☐ No ☐ Unknown
If yes, when: _____ Where (county or state if outside of NJ): _____
History of splenectomy? ☐ Yes ☐ No ☐ Unknown
If yes, when: _____
Recent blood transfusion? ☐ Yes ☐ No ☐ Unknown
If yes, when: _____ Where: _____
Was infection transfusion related? ☐ Yes ☐ No
Was immunosuppressive condition (e.g., HIV, neoplastic disease or others) present? ☐ Yes ☐ No
If yes, specify: _____

Laboratory Tests (Describe or attach copy of lab reports.): Date of Specimen Collection

1. Blood smear positive for Babesia: ☐ Yes ☐ No ☐ Not Done ____ / ____ / ____
   (If Yes, please submit one diagnostic slide to PHEL in Trenton.)
2. IFA, Total: ☐ Positive ☐ Negative ☐ Indeterminate
   IFA, IgM: ☐ Positive ☐ Negative ☐ Indeterminate
   IFA, IgG: ☐ Positive ☐ Negative ☐ Indeterminate
3. Other tests positive for *Babesia* (e.g., PCR): ☐ Yes ☐ No ☐ Not Done ____ / ____ / ____
   If yes, specify: _____

Treatment:

Was patient treated with antibiotics for this infection? ☐ Yes ☐ No
If yes, specify which drug(s) *(Check all that apply)*:
☐ Clindamycin ☐ Quinine ☐ Atovaquone ☐ Azithromycin ☐ Other

Name and Title of Person Submitting Report	Telephone Number