



# Lyme Disease

County \_\_\_\_\_

Case name (last, first) \_\_\_\_\_  
 Birth date \_\_\_/\_\_\_/\_\_\_ Age at symptom onset \_\_\_\_\_  Years  Months  
 Alternate name \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Address type  Home  Mailing  Other  Temporary  Work  
 Street address \_\_\_\_\_  
 City/State/Zip/County \_\_\_\_\_  
 Residence type (incl. Homeless) \_\_\_\_\_ WA resident  Yes  No

## ADMINISTRATIVE

Investigator \_\_\_\_\_ LHM Case ID (optional) \_\_\_\_\_

LHM notification date \_\_\_/\_\_\_/\_\_\_

### Classification

Classification pending  Confirmed  Investigation in progress  Not reportable  Probable  Ruled out  Suspect

### Investigation status

Complete  Complete – not reportable to DOH  Unable to complete Reason \_\_\_\_\_  In progress

Dates: **Investigation start** \_\_\_/\_\_\_/\_\_\_ Investigation complete \_\_\_/\_\_\_/\_\_\_ Record complete \_\_\_/\_\_\_/\_\_\_ **Case complete** \_\_\_/\_\_\_/\_\_\_

## REPORT SOURCE

**Initial report source** \_\_\_\_\_ LHM \_\_\_\_\_

Reporter organization \_\_\_\_\_

Reporter name \_\_\_\_\_ Reporter phone \_\_\_\_\_

All reporting sources (list all that apply) \_\_\_\_\_

## DEMOGRAPHICS

Sex at birth:  Female  Male  Other  Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

**Ethnicity**  Hispanic, Latino/a, Latinx  Non-Hispanic, Latino/a, Latinx  Patient declined to respond  Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

**Race**  Amer Ind/AK Native (*specify*:  Amer Ind *and/or*  AK Native)  Asian  Black or African American  
 Native HI/Pacific Islander (*specify*:  Native HI *and/or*  Pacific Islander)  White  Patient declined to respond  Unk

Additional race information:

Afghan  Afro-Caribbean  Arab  Asian Indian  Bamar/Burman/Burmese  Bangladeshi  Bhutanese  
 Central American  Cham  Chicano/a or Chicanx  Chinese  Congolese  Cuban  Dominican  Egyptian  
 Eritrean  Ethiopian  Fijian  Filipino  First Nations  Guamanian or Chamorro  Hmong/Mong  
 Indigenous-Latino/a or Indigenous-Latinx  Indonesian  Iranian  Iraqi  Japanese  Jordanian  Karen  
 Kenyan  Khmer/Cambodian  Korean  Kuwaiti  Lao  Lebanese  Malaysian  Marshallese  Mestizo  
 Mexican/Mexican American  Middle Eastern  Mien  Moroccan  Nepalese  North African  Oromo  
 Pakistani  Puerto Rican  Romanian/Rumanian  Russian  Samoan  Saudi Arabian  Somali  
 South African  South American  Syrian  Taiwanese  Thai  Tongan  Ugandan  Ukrainian  
 Vietnamese  Yemeni  Other: \_\_\_\_\_

What is your (your child's) preferred language? Check one:

Amharic  Arabic  Balochi/Baluchi  Burmese  Cantonese  Chinese (unspecified)  Chamorro  Chuukese  
 Dari  English  Farsi/Persian  Fijian  Filipino/Pilipino  French  German  Hindi  Hmong  Japanese  
 Karen  Khmer/Cambodian  Kinyarwanda  Korean  Kosraean  Lao  Mandarin  Marshallese  Mixteco  
 Nepali  Oromo  Panjabi/Punjabi  Pashto  Portuguese  Romanian/Rumanian  Russian  Samoan  
 Sign languages  Somali  Spanish/Castilian  Swahili/Kiswahili  Tagalog  Tamil  Telugu  Thai  Tigrinya  
 Ukrainian  Urdu  Vietnamese  Other language: \_\_\_\_\_  Patient declined to respond  Unknown

Interpreter needed  Yes  No  Unk

**EMPLOYMENT AND SCHOOL**

Employed  Yes  No  Unk Occupation \_\_\_\_\_ Industry \_\_\_\_\_  
 Employer \_\_\_\_\_ Work site \_\_\_\_\_ City \_\_\_\_\_

Student/Day care  Yes  No  Unk  
 Type of school  Preschool/day care  K-12  College  Graduate School  Vocational  Online  Other  
 School name \_\_\_\_\_ School address \_\_\_\_\_  
 City/State/County \_\_\_\_\_ Zip \_\_\_\_\_ Phone number \_\_\_\_\_ Teacher's name \_\_\_\_\_

**COMMUNICATIONS**

Primary HCP name \_\_\_\_\_ Phone \_\_\_\_\_  
 OK to talk to patient (If Later, provide date)  Yes  Later \_\_\_/\_\_\_/\_\_\_  Never  
 Date of interview attempt \_\_\_/\_\_\_/\_\_\_  Complete  Partial  Unable to reach  Patient could not be interviewed  
 Alternate contact:  Parent/Guardian  Spouse/Partner  Friend  Other \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Outbreak related  Yes  No LHJ Cluster ID \_\_\_\_\_ Cluster Name \_\_\_\_\_

**CLINICAL INFORMATION**

Complainant ill  Yes  No  Unk **Symptom Onset** \_\_\_/\_\_\_/\_\_\_  **Derived** Diagnosis date \_\_\_/\_\_\_/\_\_\_  
 Illness duration \_\_\_\_\_  Days  Weeks  Months  Years

**Clinical Features****Y N Unk**

- Asymptomatic (no clinical illness)  
   **Erythema migrans** (bull's eye rash)  
   **≥ 5 cm diameter diagnosed by a healthcare provider** Number of EM lesions \_\_\_\_\_  
   Other rash or lesion Appearance/progression \_\_\_\_\_  
   Any fever, subjective or measured Temp measured?  Yes  No Highest measured temp \_\_\_\_\_°F  
   Chills or rigors  
   Fatigue  
   Malaise  
   Headache  
   Myalgia (muscle aches or pain)  
   Arthralgia (joint pain)

**Y N Unk**

- Arthritis with objective joint swelling** Joint  Elbow  Knee  Other \_\_\_\_\_  
   **Recurrent**  
   Chronic arthritis  
   **Cranial neuritis (e.g., Bell's palsy)**  
   **Radiculoneuropathy**  
   Nuchal rigidity (stiff neck)  
   **Encephalitis or encephalomyelitis**  
   **Lymphocytic meningitis**  
   **AV conduction defect**  
   Myocarditis  
   Myocardial infarction  
   Regional lymphadenitis (bubo) Size \_\_\_\_\_  
   Erythematous  
   Tender  
 Body site  Axillary  Cervical  Femoral  Inguinal  Pharyngeal  Other location \_\_\_\_\_  
   Other symptoms consistent with this illness \_\_\_\_\_  
   Acute respiratory distress syndrome (ARDS) Diagnosed by  X-Ray  CT  MRI  Provider only  
   Congestive heart failure  
   Disseminated intravascular coagulopathy (DIC)  
   Liver failure  
   **Physician diagnosis of Lyme disease**  
 White blood cell value in CSF \_\_\_\_\_

**Hospitalization**

Y N Unk

Hospitalized at least overnight for this illness Facility name \_\_\_\_\_  
Hospital admission date \_\_\_/\_\_\_/\_\_\_ Discharge \_\_\_/\_\_\_/\_\_\_ HRN \_\_\_\_\_

Y N Unk

Admitted to ICU Date admitted to ICU \_\_\_/\_\_\_/\_\_\_ Date discharged from ICU \_\_\_/\_\_\_/\_\_\_  
   Mechanical ventilation or intubation required  
   Still hospitalized As of \_\_\_/\_\_\_/\_\_\_

Y N Unk

Died of this illness Death date \_\_\_/\_\_\_/\_\_\_ Please fill in the death date information on the Person Screen  
   Autopsy performed  
   Death certificate lists disease as a cause of death or a significant contributing condition  
Location of death  Outside of hospital (e.g., home or in transit to the hospital)  Emergency department (ED)  
 Inpatient ward  ICU  Other \_\_\_\_\_

**Pregnancy**

Pregnancy status at time of symptom onset

Pregnant (Estimated) delivery date \_\_\_/\_\_\_/\_\_\_ Weeks pregnant at any symptom onset \_\_\_\_\_  
OB name, phone, address \_\_\_\_\_  
Outcome of pregnancy  Still pregnant  Fetal death (miscarriage or stillbirth)  Abortion  
 Other \_\_\_\_\_  
 Delivered – full term  Delivered – preemie  Delivered – Unk  
Delivery method  Vaginal  C-section  Unk  
 Postpartum (Estimated) delivery date \_\_\_/\_\_\_/\_\_\_  
OB name, phone, address \_\_\_\_\_  
Outcome of pregnancy  Fetal death (miscarriage or stillbirth)  Abortion  
 Other \_\_\_\_\_  
 Delivered – full term  Delivered – preemie  Delivered – Unk  
Delivery method  Vaginal  C-section  Unk  
 Neither pregnant nor postpartum  Unk

**RISK AND RESPONSE (Ask about exposures 3-32 days before symptom onset)**

**Travel**

	Setting 1	Setting 2	Setting 3
<b>Travel out of:</b>	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	____/____/____ to ____/____/____	____/____/____ to ____/____/____	____/____/____ to ____/____/____

**Risk and Exposure Information**

Y N Unk

Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country \_\_\_\_\_

Y N Unk

Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)  
Activity  Outdoor recreation  Cabin  Hunting  Lawn mowing  Other \_\_\_\_\_  
Habitat  Wooded/brushy  Grassy  Other \_\_\_\_\_  
Where  At home property  Elsewhere \_\_\_\_\_

**Has been in a wooded, brushy, or grassy area (i.e., potential tick habitat) in the 30 days prior to onset**

Tick bite Date \_\_\_/\_\_\_/\_\_\_ Location  WA County \_\_\_\_\_  Other state  Other country  
 Multiple exposures  Unk

Specify location \_\_\_\_\_

**Travel to a high incidence state (10 confirmed cases/100,000 population) in the 30 days before onset**

No risk factors of likely exposures could be identified

**Exposure and Transmission Summary**

Likely geographic region of exposure  In Washington – county \_\_\_\_\_  Other state \_\_\_\_\_  
 Not in US - country \_\_\_\_\_  Unk

International travel related  During entire exposure period  During part of exposure period  No international travel

Suspected exposure type  Vectorborne  Blood products  Other \_\_\_\_\_

Exposure Summary

**Public Health Interventions/Actions**

Y N Unk

   Letter sent Date \_\_\_/\_\_\_/\_\_\_ Batch date \_\_\_/\_\_\_/\_\_\_**TREATMENT**

Y N Unk

   Did patient receive prophylaxis/treatment

Specify antibiotic \_\_\_\_\_

Number of days actually taken \_\_\_\_\_ Treatment start date \_\_\_/\_\_\_/\_\_\_ Treatment end date \_\_\_/\_\_\_/\_\_\_

**NOTES****LAB RESULTS**Lab report information**Lab report reviewed – LHJ** 

WDRS user-entered lab report note

Submitter \_\_\_\_\_

Performing lab for entire report \_\_\_\_\_

Referring lab \_\_\_\_\_

Specimen**Specimen identifier/accession number** \_\_\_\_\_**Specimen collection date** \_\_\_/\_\_\_/\_\_\_ **Specimen received date** \_\_\_/\_\_\_/\_\_\_**WDRS specimen type** \_\_\_\_\_

WDRS specimen source site \_\_\_\_\_

WDRS specimen reject reason \_\_\_\_\_

Test performed and result**WDRS test performed** \_\_\_\_\_**WDRS test result, coded** \_\_\_\_\_

WDRS test result, comparator \_\_\_\_\_

**WDRS result, numeric only** (enter only if given, including as necessary **Comparator** and **Unit of measure**) \_\_\_\_\_

WDRS unit of measure \_\_\_\_\_

Test method \_\_\_\_\_

WDRS interpretation code \_\_\_\_\_

Test result – Other, specify \_\_\_\_\_

**WDRS result summary**  Positive  Negative  Indeterminate  Equivocal  Test not performed  PendingTest result status  Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date \_\_\_/\_\_\_/\_\_\_

**Upload document**Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [doh.information@doh.wa.gov](mailto:doh.information@doh.wa.gov).