North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

EHRLICHIOSIS, HGA

Confidential Communicable Disease Report—Part 2

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Name of laboratory_____ City_____ State_____ ZIP_____

SEROLOGIC TESTS Indicate Y(es) or N(o) ONLY if the test was performed.	SEROLOGY 1 Collection Date (mm/dd/yyyy) _____ Specimen # _____ Titer/Result	Positive?	SEROLOGY 2 Collection Date (mm/dd/yyyy) _____ Specimen # _____ Titer/Result	Positive?
IFA-IgG	(_____)	☐Y ☐N	(_____)	☐Y ☐N
IFA-IgM	(_____)	☐Y ☐N	(_____)	☐Y ☐N
Other test:_____	(_____)	☐Y ☐N	(_____)	☐Y ☐N

Was there a fourfold change in antibody titer between the two serum specimens? ☐Y ☐N

Other Diagnostic Tests?	Positive?
PCR	☐Y ☐N
Morulae visualization	☐Y ☐N
Immunostain	☐Y ☐N
Culture	☐Y ☐N

Comments/details:

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐Y ☐N ☐U
Headache ☐Y ☐N ☐U
Meningitis ☐Y ☐N ☐U
Encephalitis ☐Y ☐N ☐U
Muscle aches/pains (myalgias) ☐Y ☐N ☐U
Thrombocytopenia ☐Y ☐N ☐U
Leukopenia ☐Y ☐N ☐U
Anemia ☐Y ☐N ☐U
Elevated liver enzymes ☐Y ☐N ☐U

TREATMENT

Did patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U
If yes:
Check all antibiotics that apply:
☐ Doxycycline ☐ Chloramphenicol
☐ Unknown
☐ Other (specify)_____
Date antibiotic began (mm/dd/yyyy): ____/____/____
If no:
Did patient refuse treatment? ☐Y ☐N ☐U

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

CLINICAL FINDINGS

Acute respiratory distress syndrome (ARDS) ☐Y ☐N ☐U
Acute renal failure ☐Y ☐N ☐U
Disseminated intravascular coagulation ☐Y ☐N ☐U
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U
If yes, specify:

PREDISPOSING CONDITIONS

Any immunosuppressive conditions ☐Y ☐N ☐U
Please specify:

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____
_____
Survived? ☐Y ☐N ☐U
Status at time of report:
☐ Fully recovered
☐ Survived but experiencing sequelae (residual deficit from illness) at time of report
Died? ☐Y ☐N ☐U
Died from this illness? ☐Y ☐N ☐U
Date of death (mm/dd/yyyy):_____/_____/_____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident NC
- ☐ Resident of another state or US territory
- ☐ None of the above

Did patient have a travel history during the 14 days prior to onset of symptoms? ..... ☐ Y ☐ N ☐ U

List travel dates and destinations _____

_____

_____

Additional travel/residency information:

VECTOR EXPOSURES

During the 14 days prior to onset of symptoms, did the patient have an opportunity for exposure to ticks? ..... ☐ Y ☐ N ☐ U

Exposed on (mm/dd/yyyy): ____/____/____

Until (mm/dd/yyyy): ____/____/____

Frequency
- ☐ Once
- ☐ Multiple times within this time period
- ☐ Daily

Exposure setting _____

City/county of exposure_____

State of exposure _____

Country of exposure _____

Was the tick embedded? ..... ☐ Y ☐ N ☐ U

How long?_____
- ☐ Hours
- ☐ Days
- ☐ Unknown

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ..... ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): ____/____/____

Medical records reviewed (including telephone review with provider/office staff)? ..... ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County_____

☐ Outside NC, but within US

City _____

State _____

County_____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ..... ☐ Y ☐ N

Notes: