CONFIDENTIAL COMMUNICABLE DISEASE REPORT—Part 2

LYME DISEASE

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

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.

**LAB RESULTS**

<table>
<thead>
<tr>
<th>Specimen Date</th>
<th>Specimen #</th>
<th>Source</th>
<th>Type of Test</th>
<th>Description (comments)</th>
<th>Result Date</th>
<th>Lab Name—City/State</th>
</tr>
</thead>
<tbody>
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**REASON FOR TESTING**

Why was the patient tested for this condition?
- Symptomatic of disease
- Tick bite without symptoms of disease
- Other
- Unknown

**PREDISPOURING CONDITIONS**

- Any immunosuppressive conditions
  - Specify
- Autoimmune disease
  - Specify:
    - Systemic lupus erythematosus
    - Rheumatoid arthritis
    - Other
    - Specify
- Other underlying illness
  - Specify

**TREATMENT**

Did the patient take an antibiotic as treatment for this illness?
- Yes
- No
- Unknown

Specify antibiotic name:
- Antibiotic name unknown

Date antibiotic began (mm/dd/yyyy)

**CLINICAL FINDINGS**

Other symptoms, signs, clinical findings, or complications consistent with this illness
- Specify

Notes:

**DIFFERENTIAL DIAGNOSES**

- Bell’s Palsy
- Cranial neuritis, including
  - Bell’s Palsy
- Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints
- Arthritis
  - Extent:
    - One joint
    - Multiple joints

Specify location(s)

- Type: Septic
- Reactive
- Other

Specify Recurrent

**Erythema migrans (bulls-eye skin lesion)**

- Onset date (mm/dd/yyyy): __/__/____

**Other Symptoms**

- Onset date (mm/dd/yyyy): __/__/____

**Myocarditis**

- Onset date (mm/dd/yyyy): __/__/____

**Encephalitis**

- Onset date (mm/dd/yyyy): __/__/____

**Meningitis**

- Onset date (mm/dd/yyyy): __/__/____

**Encephalomyelitis/meningoencephalitis**

- Onset date (mm/dd/yyyy): __/__/____

**Radiculoneuropathy**

- Onset date (mm/dd/yyyy): __/__/____

**Other symptoms**

- Other symptoms, signs, clinical findings, or complications consistent with this illness
- Specify

**Other Symptoms**

- Description (comments)

**Other Symptoms**

- Onset date (mm/dd/yyyy): __/__/____

**Other Symptoms**

- Other symptoms, signs, clinical findings, or complications consistent with this illness
- Specify

**Other Symptoms**

- Description (comments)

**Other Symptoms**

- Onset date (mm/dd/yyyy): __/__/____

**Other Symptoms**

- Other symptoms, signs, clinical findings, or complications consistent with this illness
- Specify

**Other Symptoms**

- Description (comments)

**Other Symptoms**

- Onset date (mm/dd/yyyy): __/__/____

**Other Symptoms**

- Other symptoms, signs, clinical findings, or complications consistent with this illness
- Specify
**HOSPITALIZATION INFORMATION**

- **Was patient hospitalized for this illness >24 hours?** [ ] Yes [ ] No [ ] Unsure
  - **Hospital name:** [ ]
  - **City, State:** [ ]
  - **Hospital contact name:** [ ]
  - **Telephone:** [ ]
  - **Admit date (mm/dd/yyyy):** [ ]
  - **Discharge date (mm/dd/yyyy):** [ ]

**VECTOR EXPOSURES**

- **During the 30 days prior to onset, did the patient have an opportunity for exposure to ticks?** [ ] Yes
  - **Exposed on (mm/dd/yyyy):** [ ]
  - **Until (mm/dd/yyyy):** [ ]
  - **Frequency:** [ ]
    - [ ] Once
    - [ ] Multiple times within this time period
    - [ ] Daily
  - **County of exposure:** [ ]
  - **State of exposure:** [ ]
  - **Country of exposure:** [ ]
  - **Was the tick embedded?** [ ] Yes [ ] No [ ] Unsure
  - **How long?** [ ]
    - [ ] Hours
    - [ ] Days
    - [ ] Unknown
  - **Notes:** [ ]

**CASE INTERVIEWS/INVESTIGATIONS**

- **Date of interview (mm/dd/yyyy):** [ ]
- **Medical records reviewed (including telephone review with provider/office staff)?** [ ] Yes [ ] No [ ] Unsure
  - **Specify reason if medical records were not reviewed:** [ ]

**CLINICAL OUTCOMES**

- **Discharge/Final diagnosis:** [ ]
- **Survived?** [ ] Yes [ ] No [ ] Unsure
- **Died?** [ ] Yes [ ] No [ ] Unsure
- **Died from this illness?** [ ] Yes [ ] No [ ] Unsure
  - **Date of death (mm/dd/yyyy):** [ ]

**TRAVEL/IMMIGRATION**

- **The patient is:** [ ] Resident of NC
  - [ ] Resident of another state or US territory
  - [ ] None of the above
- **Did patient have a travel history during the 30 days prior to onset?** [ ] Yes [ ] No [ ] Unsure
  - **List travel dates and destinations:** [ ]

**GEOGRAPHICAL SITE OF EXPOSURE**

- **In what geographic location was the patient MOST LIKELY exposed?**
  - [ ] In NC
    - **City:** [ ]
  - [ ] County
    - **County:** [ ]
  - [ ] Outside NC, but within US
    - **City:** [ ]
    - **State:** [ ]
    - **County:** [ ]
  - [ ] Outside US
    - **City:** [ ]
    - **Country:** [ ]
  - [ ] Unknown
- **Is the patient part of an outbreak of this disease?** [ ] Yes [ ] No [ ] Unsure
  - **Notes:** [ ]

**VACCINE**

- **Has patient/contact ever received vaccine for this disease?** [ ] Yes [ ] No [ ] Unsure
  - **Vaccine type:** [ ]
  - **Date of administration (mm/dd/yyyy):** [ ]
  - **Source of this vaccine information:** [ ]