



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
Travel out of:	<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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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