WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Lyme Disease Reporting Form

PATIENT DEMOGRAPHICS

*Name (last, first): _____
*Address (mailing): _____
*Address (physical): _____
*City/State/Zip: _____
*Phone (home): _____ Phone (work/cell) : _____
Alternate contact: ☐Parent/Guardian ☐Spouse ☐Other
Name: _____ Phone: _____

*Birth date: __ / __ / ____ *Age: _____
*Sex: ☐Male ☐Female ☐Unk
*Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
*Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐Unk

INVESTIGATION SUMMARY

Local Health Department (LHD) (Jurisdiction): _____
Investigation start date: __ / __ / ____
Earliest date reported to LHD: __ / __ / ____
Earliest date reported to State: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐HCP ☐Public Health Agency ☐Other
Reporter Name: _____ Reporter Phone: _____
Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __ / __ / ____ **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

*CLINICAL FINDINGS

Y N U
☐ ☐ ☐ Diagnosed as Lyme disease by physician
☐ ☐ ☐ Physician-diagnosed **erythema migrans** (EM) measuring 5cm or greater in diameter
☐ ☐ ☐ Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints
☐ ☐ ☐ Cranial neuritis (e.g., Bell's palsy)
☐ ☐ ☐ Radiculoneuropathy
☐ ☐ ☐ Lymphocytic meningitis
☐ ☐ ☐ Encephalomyelitis
☐ ☐ ☐ Acute onset 2nd or 3rd degree atrioventricular conduction defects that resolve in days to weeks

Hospitalization

Y N U
☐ ☐ ☐ Patient hospitalized for this illness
Hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Death

Y N U
☐ ☐ ☐ Patient died due to this illness If yes, date of death: __ / __ / ____

VACCINATION HISTORY

Y N U
☐ ☐ ☐ Previously received Lyme disease vaccine
If yes, date: __/__/____

TREATMENT

Y N U
☐ ☐ ☐ Patient received antibiotic therapy due to this infection
If yes, specify:
Type: _____ Duration: _____ days

LABORATORY *(Please submit copies of all labs obtained on this case to Division of Infectious Disease Epidemiology)*

Y N U
☐ ☐ ☐ *Culture positive for *B. burgdorferi*
☐ ☐ ☐ *Culture positive for *B. mayonii*
☐ ☐ ☐ *Detection of *B. burgdorferi* by nucleic acid amplification test
☐ ☐ ☐ *Detection of *B. mayonii* by nucleic acid amplification test
☐ ☐ ☐ *Detection of *B. burgdorferi* group-specific antigens in biopsy or autopsy by immunohistochemical assay
☐ ☐ ☐ *Serum antibody positive for *B. burgdorferi* by EIA or IFA
☐ ☐ ☐ *Western immunoblot positive for *B. burgdorferi*-specific IgM (onset ≤30 days)
☐ ☐ ☐ *Western immunoblot positive for *B. burgdorferi*-specific IgG (at any point during illness)

INFECTION TIMELINE

Instructions: Enter onset date in grey box. Count backward to determine probable exposure period.

	Exposure period		Onset date
Days from onset	***-32 (Max Incubation)***	***-3 (Min Incubation)***	
Calendar dates:	__ / __ / ____	__ / __ / ____	__ / __ / ____

EPIDEMIOLOGIC EXPOSURES (refer to above exposure period; do not complete this section if no EM is documented)

Y N U

☐ ☐ ☐ History of travel during exposure period (if yes, complete travel history below):

Destination (City, County, State and Country)	Arrival Date	Departure Date	Reason for travel

☐ ☐ ☐ Potential occupational exposure (i.e., outdoor work in potential tick habitats)
If yes, list occupation:_____

Where did exposure most likely occur? **County:** _____ **State:**_____ **Country:** _____

PUBLIC HEALTH ISSUES

Y N U

☐ ☐ ☐ Case knows someone who had shared exposure and is currently having similar symptoms
☐ ☐ ☐ Epi link to another confirmed case of same condition
☐ ☐ ☐ Case is part of an outbreak
☐ ☐ ☐ Other:

PUBLIC HEALTH ACTIONS

Y N U

☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian
☐ ☐ ☐ Recommended environmental measures to patient/family to reduce risk around home
☐ ☐ ☐ Education or outreach provided to employer
☐ ☐ ☐ Facilitate laboratory testing of other symptomatic persons who have a shared exposure
☐ ☐ ☐ Patient is lost to follow-up
☐ ☐ ☐ Other:

WVEDSS

Y N U

☐ ☐ ☐ Entered into WVEDSS (**Entry date**: __ / __ / ____) **Case Status:** ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

NOTES