Lyme Disease

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Investigation Information

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	First Name*	Middle Initial

Street Address

City	County	State	Zip
		West Virginia	

Is the patient's residence a:

○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____

○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.	Report Date mm/dd/yyyy

Parent / Guardian Information

Last Name	First Name	Middle Initial	Relationship to Patient

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	County	State	Zip
		West Virginia	

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	Age	Age Units
		○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Patient Demographic Information cont.

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native*
☐ *Asian*
☐ *Black or African American*
☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White*
☐ *Unknown*
☐ *Failure to report race/missing race*
☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms
mm/dd/yyyy

Date of diagnosis
mm/dd/yyyy

Was patient hospitalized for this disease?

○ *Yes* ○ *No* ○ *Unknown*

Name of Hospital

Date of Admission
mm/dd/yyyy

Patient outcome from this disease:

○ *Died* ○ *Survived* ○ *Unknown*

Date of Death
mm/dd/yyyy

Symptoms and signs of current episode:

Erythema migrans?
(Physician diagnosed EM at least 5 cm in diameter?)

○ *Yes* ○ *No* ○ *Unknown*

Arthritis characterized by brief attacks of joint swelling?

○ *Yes* ○ *No* ○ *Unknown*

Bell's palsy or other cranial neuritis?

○ *Yes* ○ *No* ○ *Unknown*

Radiculoneuropathy?

○ *Yes* ○ *No* ○ *Unknown*

Lymphocytic meningitis?

○ *Yes* ○ *No* ○ *Unknown*

Encephalitis/Encephalomyelitis?

○ *Yes* ○ *No* ○ *Unknown*

CSF tested for antibodies to B. burgdorferi?

○ *Yes* ○ *No* ○ *Unknown*

Antibodies to B. burgdorferi higher in CSF than serum?

○ *Yes* ○ *No* ○ *Unknown*

2nd or 3rd degree atrioventricular block?

○ *Yes* ○ *No* ○ *Unknown*

Other Clinical

Other clinical history:

Name of antibiotic used this episode?

Use in days?

Was the patient pregnant at the time of illness?

○ *Yes* ○ *No* ○ *Unknown*

Where was the patient most likely exposed?

County:

State:

Laboratory Data

Specimen Source	Specimen Date	Name of Test	If Other, Specify	Result	Normal Range
	mm/dd/yyyy	(select one)		(select one)	

Laboratory Name	Phone ###-###-####	Ext.	Fax Number ###-###-####

Address

State:	Zip:
West Virginia	

Provider who ordered the test:

○ *Check here if provider is same as submitter*

Last Name	First Name	Phone ###-###-####	Ext.

Address

City	State	Zip
	West Virginia	

Reporting Source

Last Name	First Name

Phone ###-###-####	Ext.	Fax ###-###-####

Facility

Address

City	State	Zip
	West Virginia	

E-mail

Provider with Further Patient Information

Last Name	First Name

Phone ###-###-####	Ext.	Fax ###-###-####

Provider with Further Patient Information cont.

Address		
City	**State** West Virginia	**Zip**

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy

Investigator	Date public health investigation began mm/dd/yyyy	Health Department	Phone ###-###-####

Ext.	

Investigation ID	Part of an Outbreak? ○ *Yes* ○ *No* ○ *Unknown*	Outbreak Name	Lost to follow-up? ○ *Yes* ○ *No*

Public Health Action Taken

Describe public health action taken