Tick-Borne Disease Case Report

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

Disease Under Investigation

*indicates required fields

○ *Ehrlichiosis; Human Granulocytic (HGE)* ○ *Ehrlichiosis; (unspecified, or other agent):*

○ *Ehrlichiosis; Human Monocytic (HME)* ○ *Rocky Mountain Spotted Fever (RMSF)*

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○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*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 the patient hospitalized for the 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

Was clinically compatible illness present (fever or rash, plus one or more of the following signs: headache, myalgia, anemia, thrombocytopenia leucopenia, or elevated hepatic transaminases)?

○ *Yes* ○ *No*

Was an underlying immunosuppressive condition present?

○ *Yes* ○ *No* ○ *Unknown*

If yes, specify:

○ *No* ○ *Yes*

Specify any life-threatening complications in the clinical course of illness

(Check all that apply)

☐ *Adult respiratory distress syndrome (ARDS)*
☐ *Disseminated Intravascular Coagulopathy (DIC)*
☐ *Meningitis/Encephalitis*
☐ *Renal failure*
☐ *None*
☐ *Other, specify*_____

Laboratory Data

Name of Laboratory

City	**State**	**Zip**	**Telephone number**
	West Virginia		###-###-####

No.	Serologic Tests	Date of Collection	Titer	Result	Normal Range
	IgM=IgM IFA IgG=IgG IFA Oth=Other test (see below)	mm/dd/yyyy	(if applicable)	1=Positive 2=Negative 9=Unknown	
1					
2					
3					
4					
5					

Specify other serologic test:

Was there a four fold change in antibody titer between the two serum specimens?

○ *Yes* ○ *No* ○ *Unknown*

Other Diagnostic Tests?	Date of Collection	Result
	mm/dd/yyyy	P=Positive N=Negative NP=Not Performed
PCR		
Moruale visualization (not applicable for RMSF)		
Immunostain		
Culture		

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

Address	**State:**	**Zip:**
	West Virginia	

Reporting Source

Last Name	First Name	
Phone ###-###-####	**Ext.**	**Fax** ###-###-####
Facility		
Address		
City	**State** West Virginia	**Zip**
E-mail		

Provider with Further Patient Information

Last Name	First Name	
Phone ###-###-####	**Ext.**	**Fax** ###-###-####
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?	Outbreak Name	Lost to follow-up?
	○ *Yes* ○ *No* ○ *Unknown*		○ *Yes* ○ *No*

Describe Public Health Action Taken