

According to Section 2.1 of the NYS Sanitary Code, all of the following material is required to complete a Lyme Disease Report.  
Please fill in all blanks

Patient's Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Number and Street

\_\_\_\_\_  
City/Town/Village

Ethnicity:  Hispanic  Non-Hispanic

Race:  White  Black  Asian  
 American Indian/Alaskan  
 Native Hawaiian/Other Pacific  
Islander  Other  Unknown

Occupation/Setting:  Day Care  
 Food Service  Health Care  
 Student/School  Inmate  
 Unknown  
 Other \_\_\_\_\_

Sex:  Male  Female

Pregnant:  Yes  No

Hospitalized?  Yes  No Admission Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hospital: \_\_\_\_\_ Chart # \_\_\_\_\_

Date of First Symptom: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Report: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reporting Individual: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

**CLINICAL INFORMATION: check box Yes, No or Unknown**

	Yes	No	Unknown
Has MD/Provider diagnosed this patient with Lyme disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has patient been tested for other tick-borne infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MD/Provider diagnosed EM/Erythema migrans $\geq$ 5 cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, with observed objective joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, without observed objective joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cranial neuritis (Bell's Palsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphocytic Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiculoneuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lyme Encephalomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute 2 or 3 degree A-V conduction defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Symptoms:  
 Headache  Fever  Malaise  
 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tick Bite?  Yes  No  Unknown Date of Bite: \_\_\_\_/\_\_\_\_/\_\_\_\_ Species: \_\_\_\_\_ Sent for ID?  Yes  No  Unk

**TREATMENT:**

Date treatment initiated: \_\_\_\_/\_\_\_\_/\_\_\_\_ Duration Prescribed: \_\_\_\_\_ days Medication: \_\_\_\_\_

History of Babesiosis:  Yes  No  Unknown Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

History of Ehrlichiosis:  Yes  No  Unknown Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

**LABORATORY RESULTS:** Date Collected: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Results Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

ELISA/ELA/IFA: Total Ab (IgG & IgM)  POS  NEG  EQUIV  UNKNOWN

C6 Elisa  POS  NEG  EQUIV  UNKNOWN

WESTERN BLOT: IgG blot  POS  NEG  EQUIV  UNKNOWN

IgM blot  POS  NEG  EQUIV  UNKNOWN

Other Positive Test: \_\_\_\_\_ Revised103108mjf