

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

EHRlichiosis, Unspecified

Confidential Communicable Disease Report—Part 2

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Name of laboratory _____ City _____ State _____ ZIP _____

SEROLOGIC TESTS Indicate Y(es) or N(o) ONLY if the test was performed.	SEROLOGY 1		SEROLOGY 2		Other Diagnostic Tests?	Positive?
	Collection Date (mm/dd/yyyy)	Specimen #	Collection Date (mm/dd/yyyy)	Specimen #		
IFA-IgG	()	<input type="checkbox"/> Y <input type="checkbox"/> N	()	<input type="checkbox"/> Y <input type="checkbox"/> N	PCR	<input type="checkbox"/> Y <input type="checkbox"/> N
IFA-IgM	()	<input type="checkbox"/> Y <input type="checkbox"/> N	()	<input type="checkbox"/> Y <input type="checkbox"/> N	Morulae visualization	<input type="checkbox"/> Y <input type="checkbox"/> N
Other test: _____	()	<input type="checkbox"/> Y <input type="checkbox"/> N	()	<input type="checkbox"/> Y <input type="checkbox"/> N	Immunostain	<input type="checkbox"/> Y <input type="checkbox"/> N
					Culture	<input type="checkbox"/> Y <input type="checkbox"/> N

Comments/details:

Was there a fourfold change in antibody titer between the two serum specimens? Y N

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U

If yes, symptom onset date (mm/dd/yyyy): ___/___/___

CHECK ALL THAT APPLY:

Fever Y N U

Headache Y N U

Meningitis Y N U

Encephalitis Y N U

Muscle aches/pains (myalgias) Y N U

Thrombocytopenia Y N U

Leukopenia Y N U

Anemia Y N U

Elevated liver enzymes Y N U

PREDISPOSING CONDITIONS

Any immunosuppressive conditions Y N U

Please specify:

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: () -

Admit date (mm/dd/yyyy): ___/___/___

Discharge date (mm/dd/yyyy): ___/___/___

CLINICAL FINDINGS

Acute respiratory distress syndrome (ARDS) Y N U

Acute renal failure Y N U

Disseminated intravascular coagulation Y N U

Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U

If yes, specify:

TREATMENT

Did patient take an antibiotic as treatment for this illness? Y N U

If yes:

Check all antibiotics that apply:

Doxycycline Chloramphenicol

Unknown

Other (specify) _____

Date antibiotic began (mm/dd/yyyy): ___/___/___

If no:

Did patient refuse treatment? Y N U

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Status at time of report:

Fully recovered

Survived but experiencing sequelae (residual deficit from illness) at time of report

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ___/___/___

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

TRAVEL/IMMIGRATION

The patient is:
 Resident NC
 Resident of another state or US territory
 None of the above

Did patient have a travel history during the 14 days prior to onset of symptoms? Y N U

List travel dates and destinations _____

Additional travel/residency information:

VECTOR EXPOSURES

During the 14 days prior to onset of symptoms, did the patient have an opportunity for exposure to ticks? Y N U

Exposed on (mm/dd/yyyy): ____/____/____
 Until (mm/dd/yyyy): ____/____/____

Frequency
 Once
 Multiple times within this time period
 Daily

Exposure setting _____
 City/county of exposure _____
 State of exposure _____
 Country of exposure _____

Was the tick embedded? Y N U

How long? _____
 Hours
 Days
 Unknown

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ____/____/____

Medical records reviewed (including telephone review with provider/office staff)? Y N U
 Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:
 In NC
 City _____
 County _____
 Outside NC, but within US
 City _____
 State _____
 County _____
 Outside US
 City _____
 Country _____
 Unknown

Is the patient part of an outbreak of this disease? Y N

Notes: