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

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

LYME DISEASE
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.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

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:
Meningitis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Lymphocytic meningitis ☐Y ☐N ☐U
Encephalitis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Encephalomyelitis/ meningoencephalitis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Radiculoneuropathy ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Cranial neuritis, including Bell's Palsy ☐Y ☐N ☐U
Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints ☐Y ☐N ☐U
Arthritis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Extent: ☐ One joint ☐ Multiple joints
Specify location(s)_____
Type: ☐ Septic ☐ Reactive ☐ Other
Recurrent ☐Y ☐N ☐U
Erythema migrans (bulls-eye skin lesion) ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Diameter of largest lesion _____ x _____
☐ Centimeters ☐ Inches
Number of lesions _____
Location of lesion(s) _____
Observed by health care provider ☐Y ☐N ☐U

Myocarditis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
EKG obtained? ☐Y ☐N ☐U
Abnormal? ☐Y ☐N ☐U
Describe: _____
High degree (2nd or 3rd degree) **heart block** ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Did patient have a reactive non-treponemal test for syphilis (i.e. VDRL, TRUST, RPR)**?** ☐Y ☐N ☐U
Did the patient have CSF-VDRL? ☐Y ☐N ☐U
Result
☐ Positive ☐ Negative ☐ Unknown
Did medical provider diagnose Lyme Disease ☐Y ☐N ☐U

REASON FOR TESTING
Why was the patient tested for this condition?
☐ Symptomatic of disease
☐ Tick bite without symptoms of disease
☐ Other_____
☐ Unknown

PREDISPOSING CONDITIONS
Any immunosuppressive conditions ☐Y ☐N ☐U
Specify _____
Autoimmune disease ☐Y ☐N ☐U
Specify:
☐ Systemic lupus erythematosus
☐ Rheumatoid arthritis
☐ Other
Other underlying illness ☐Y ☐N ☐U
Specify

CLINICAL FINDINGS
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U
Specify: _____
Notes:

TREATMENT
Did the patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U
Specify antibiotic name:
_____
☐ Antibiotic name unknown
Date antibiotic began (mm/dd/yyyy) _____

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

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 OUTCOMES

Discharge/Final diagnosis: _____

_____

Survived? ☐ Y ☐ N ☐ U

Died? ☐ Y ☐ N ☐ U

Died from this illness? ☐ Y ☐ N ☐ U

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

TRAVEL/IMMIGRATION

The patient is:

☐ Resident of NC

☐ Resident of another state or US territory

☐ None of the above

Did patient have a travel history during the 30 days prior to onset? ☐ Y ☐ N ☐ U

List travel dates and destinations _____

_____

_____

Additional travel/residency information:

VECTOR EXPOSURES

During the 30 days prior to onset, did the patient have an opportunity for exposure to ticks

If yes,

Exposed on (mm/dd/yyyy): _____

Until (mm/dd/yyyy): _____

Frequency

☐ Once

☐ Multiple times within this time period

☐ Daily

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:

VACCINE

Has patient/contact ever received vaccine for this disease? ☐ Y ☐ N ☐ U

Vaccine type _____

Date of administration (mm/dd/yyyy): ____/____/____

Source of this vaccine information

_____