

**NEW HAMPSHIRE LYME DISEASE CASE REPORT FORM
HEALTH CARE PROVIDER**

Patient's Name _____ Report Date _____
(Last Name) (First Name)
Date of Birth _____ Age _____ Male Female Unknown
Address _____
City / Town _____ County _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Occupation: _____

Race
 White
 African American
 Asian
 Hawaiian or Pacific Islander
 Native Am./Alaskan Native
 Other
 Unknown
Ethnicity
 Hispanic
 Not Hispanic
 Unknown

SYMPTOMS AND SIGNS OF CURRENT EPISODE (Please answer each question)

Is this person being diagnosed with Lyme Disease?..... Yes No

Date of symptom onset _____ Onset date unknown Date of Lyme Disease diagnosis _____

DERMATOLOGIC:

Erythema migrans (physician diagnosed EM at least 5 cm in diameter)?..... Yes No Unknown

RHEUMATOLOGIC:

Arthritis characterized by recurrent brief attacks of joint swelling? Yes No Unknown

NEUROLOGIC:

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

Antibody to *B. burgdorferi* higher in CSF than serum Yes No Unknown

CARDIOLOGIC:

Acute onset 2nd or 3rd degree atrioventricular block? Yes No Unknown

Pregnant: Yes No Unknown

Hospitalized: Yes No Unknown If yes, where _____

Treatment: Doxycycline Amoxicillin Other: _____

Duration of treatment in days: _____

Has this patient been diagnosed with Lyme Disease prior to this diagnosis? Yes, date (mm/yyyy) _____ No Unknown

EXPOSURE HISTORY

Tick Bite reported within 30 days of onset: Yes No Unknown

In the 30 days prior to symptom onset, did this individual travel outside of NH: Yes, out of state Yes, out of country
 No Unknown

County and state most likely exposed? _____

LABORATORY RESULTS (Check all that apply)

EIA/IFA: Positive Equivocal Negative Not done/Unknown Date if positive: _____

Western Blot: IgM Positive IgM Negative Not done/Unknown Date if positive: _____

IgG Positive IgG Negative Not done/Unknown Date if positive: _____

Culture Results/Other: _____

HEALTH CARE PROVIDER REPORTING INFORMATION:

Reported by _____

Ordering Provider _____ Phone _____

Provider Facility _____

City/Town _____ State _____ Zip _____

For NH DHHS Staff Only

Imported

Acquired in NH
 Acquired Outside US
 Acquired in Another State
 Unknown

Case Status

Confirmed (meets CDC definitions)
 Probable (meets CDC definitions)
 Suspected (meets CDC definitions)
 Not A Case
 Out of state

Notes:

Mail or Fax to: NH Department of Health and Human Services,
Bureau of Infectious Disease Control
29 Hazen Drive, Concord, NH 03301. Fax: (603) 271-0545,
Phone: Hotline 1 (888) 836-4971. vMar14