Division of Preparedness,
Response, Infectious Disease
and EMS
3 Capitol Hill – Room 106
Providence, RI 02908

INFECTIOUS DISEASE CASE REPORT FORM

(For HIV/AIDS, STDs, and TB use disease-specific form)

To report or request forms:
Office: (401) 222-2577
After hours: (401) 272-5952
Fax: (401) 222-2488
www.health.ri.gov/diseases/for/providers

PATIENT INFORMATION (REQUIRED)

Patient's First Name | Last Name | M.I. | Date of Birth | Age | Sex ☐ Female ☐ Male

Patient's Address | City | State | Zip Code

Patient's Parent / Guardian (if patient is a minor) | Cell Phone | Home Phone

Patient Occupation: ☐ Food Handler ☐ Day Care Worker ☐ Healthcare Worker | Name of Patient's Employer/School/Day Care/ Institution/ etc.

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ White ☐ Other

Patient Pregnant? ☐ Yes ☐ No ☐ Unknown If yes, due date: _____/_____/_____ Weeks Pregnant:

Patient Hospitalized? ☐ Yes ☐ No ☐ Unknown Hospital: Admit Date: _____/_____/_____ Days in Hospital:

REPORTING SOURCE (REQUIRED)

Agency Name | Address | Telephone No. | Report Date

Ordering Physician Name | Address | Telephone No. | Diagnosis Date

DISEASE INFORMATION (REQUIRED)

Disease / Organism | Date of Illness Onset _____/_____/_____ ☐ Asymptomatic | Signs/Symptoms | Please attach all relevant lab data

Underlying Medical Condition?
☐ Yes, specify: _____
☐ No ☐ Unknown

Disease-Specific Immunization Data (immunization name and date(s))

LYME DISEASE

Is there a diagnosis of Lyme disease? ☐ Yes ☐ No If yes: Date of Diagnosis: _____/_____/_____

Did physician diagnose Erythema Migrans 5cm (2in)?: ☐ Yes ☐ No EM Onset Date: _____/_____/_____

Did patient have any of the following late manifestations: If yes: Onset Date of First Late Manifestation: _____/_____/_____

NEUROLOGIC		RHEUMATOLOGIC	
Bell's palsy/other cranial neuritis	☐ Yes ☐ No	Arthritis (objective joint swelling)	☐ Yes ☐ No
Radiculoneuropathy	☐ Yes ☐ No		
Lymphocytic meningitis	☐ Yes ☐ No		
Encephalitis/Encephalomyelitis	☐ Yes ☐ No	CARDIOLOGIC	
Antibody to *B. burgdorferi* higher in CSF than serum	☐ Yes ☐ No	2nd or 3rd degree heart/AV block	☐ Yes ☐ No

Specimen Collection Date: _____/_____/_____

Elisa results: ☐ Positive ☐ Equivocal ☐ Negative ☐ Not done

Western blot results:
☐ Positive IgG (at least 5 of the following 10 bands positive: 18kDa, 21kDa (OspC), 28kDa, 30kDa, 39kDa (BmpA), 41kDa (Fla), 45kDa, 58kDa (not GroEL), 66kDa, and 93kDa
☐ Positive IgM (at least 2 of the following 3 bands positive: 23 or 24kDa (OspC), 39kDa (BmpA), 41kDa)
☐ Not done

VARICELLA

Rash Present: ☐ Yes ☐ No Onset: _____/_____/_____ Location: | Past history of varicella? ☐ Yes ☐ No ☐ Unknown

Number of Lesions: ☐ <50 ☐ 50-249 ☐ 250-500 ☐ >500 | Lesion Type (check all that apply) ☐ Macules #: ☐ Papules #: ☐ Vesicles #:

Lab Confirmed (attach lab report): ☐ Yes ☐ No | Has individual been vaccinated? ☐ Yes ☐ No ☐ Unknown Date(s) of Vaccination:

HEPATITIS

Hepatitis Risk Factors

Sexual Preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Unknown | History of IV Drug Use: ☐ Yes ☐ No ☐ Unknown

Pregnancy Status: ☐ Yes ☐ No ☐ Sexual Partner is Pregnant ☐ Unknown

Hepatitis A, B, and C Laboratory Results (Leave blank ONLY if not done)

	Positive	Negative	Other Result (specify)	Specimen Collection Date		Positive	Negative	Other Result (specify)	Specimen Collection Date
IgM anti-HAV	☐	☐	☐		ELISA anti-HCV	☐	☐	☐	
HBsAg	☐	☐	☐		RIBA-HCV	☐	☐	☐	
IgM anti-HBc	☐	☐	☐		RT-PCR HCV (RNA)	☐	☐	☐	

AST Date: _____/_____/_____ ALT Date: _____/_____/_____ Bilirubin Date: _____/_____/_____ HCV Genotype:

AST Result: ALT Result: Bilirubin Result: