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

LYME DISEASE CASE REPORT FORM

To report or request forms:
Office: (401) 222-2577
After hours: (401) 276-8046
Fax: (401) 222-2488
www.health.ri.gov/diseases/for/providers

PATIENT INFORMATION

NAME (Last, First)			ADDRESS (Street & No.)		
CITY/TOWN	COUNTY		STATE	ZIP	PHONE

Date of Birth	Age	Sex	Ethnicity	Race
_____/_____/_____		☐Male ☐Female ☐Unknown	☐Hispanic ☐Non-Hispanic ☐Unknown	☐American Indian or Alaska Native ☐Asian ☐Black or African-American ☐Caucasian or White ☐Native Hawaiian or Other Pacific Islander ☐Other ☐Unknown

Pregnant: ☐Y ☐N ☐UNK

Hospitalized: ☐Y ☐N ☐UNK
If yes, Facility:_____ Admit Date: _____/_____/_____ Days Stayed: ____

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

Date of symptom onset: _____/_____/_____
☐Onset date unknown

Did physician diagnose Erythema Migrans ≥5cm (2in)? ☐Y ☐N
If yes, EM onset date: _____/_____/_____

Is provider diagnosing a new case of Lyme disease? ☐Y ☐N
If yes, date of diagnosis:_____/_____/_____

Has patient been previously diagnosed with Lyme? ☐Y ☐N ☐UNK
If yes, date of diagnosis:_____/_____/_____

Did patient have any of the following late manifestations? *If yes*, onset date of first late manifestation: ____/____/____

NEUROLOGIC

Bell's palsy or other cranial neuritis	☐Y	☐N
Radiculoneuropathy	☐Y	☐N
Lymphocytic meningitis	☐Y	☐N
Encephalitis/Encephalomyelitis	☐Y	☐N
Antibody to B. burgdorferi higher in CSF than serum	☐Y	☐N

RHEUMATOLOGIC

Arthritis (objective joint swelling) ☐Y ☐N

CARDIOLOGIC

Acute onset 2nd or 3rd degree atrioventricular block ☐Y ☐N

Treatment: ☐Doxycycline ☐Amoxicillin ☐Other: _____ Duration of treatment (days): _____

EXPOSURE HISTORY

Tick bite reported within 30 days of illness onset? ☐Y ☐N ☐UNK

Travel outside of RI within 30 days of illness onset? ☐Yes, out of state ☐Yes, out of country ☐No ☐Unknown

Country and state most likely exposed: _____

LABORATORY RESULTS (Check all that apply)

Specimen Collection Date: _____/_____/_____ Laboratory Name: _____

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, 45kDam 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

HEALTHCARE PROVIDER REPORTING INFORMATION

REPORTED BY		REPORT DATE		
ORDERING PROVIDER		FACILITY NAME		
CITY/TOWN	STATE	ZIP	PHONE	FAX