OSWEGO COUNTY **HEALTH DEPARTMENT**

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LYME DISEASE INVESTIGATION FORM

PHYSICIAN INFORMATION:

Name:____ **Phone:**______________________________

Facility:____ **Fax:**________________________________

PATIENT INFORMATION (Please provide any missing patient demographic information):

Last Name:__________________________ **First Name:**_____________________________ **DOB:**_________________________

Address:_____________________________**City:**__________________________ **Zip:**________ **Tel #:**_____________________

Gender (Male Female Unknown) **Pregnant** (Yes No Unknown) **Hospitalized** (Yes No ER/OutPatient)

Race (White Black American Indian/Alaskan Asian Native Hawaiian/Other Pacific Islander Other Unknown)

Ethnicity (Hispanic or Latino Not Hispanic or Latino Unknown)

Occupation (Food service Daycare Healthcare Student/School Inmate Other OCC Correction Wrk Other Unknown)

Hospital and Chart #:____ **Admission Date:**_____________________

CLINICAL INFORMATION: Date of first symptom:___________________
(Please circle responses next to patient's symptoms as appropriate)

Has a physician diagnosed this patient with Lyme disease?	Yes	No	Unknown
Has the patient been tested for other tick-borne infections?	Yes	No	Unknown
Was client bit by tick? If yes date:	Yes	No	Unknown
Erythema migrans >5cm (Physician diagnosed)	Yes	No	Unknown
Arthritis with observed joint swelling	Yes	No	Unknown
Arthritis without observed joint swelling	Yes	No	Unknown
Cranial neuritis including Bell's Palsy	Yes	No	Unknown
Lymphocytic meningitis	Yes	No	Unknown
Radiculoneuropathy	Yes	No	Unknown
Encephalomyelitis and antibody to B. burgdorferi higher in CSF than in serum	Yes	No	Unknown
Acute Secondary or Tertiary A-V conduction defect	Yes	No	Unknown
Other – Specify:	Yes	No	Unknown

LABORATORY RESULTS(if applicable):

Specimen Collection Date:	Specimen Source:	Test Type:	Test Result:

Was a Western Blot done? (Yes No) If yes, and Western Blot was negative, check here____________

TREATMENT:
Date initiated:______________ **Medication & Dose:**___________________________ **Duration Prescribed:**________

Additional Comments:____
____
____

________________________________ ________________________ ____________________
Individual Completing Form **Title** **Date**