



LYME DISEASE SURVEILLANCE FORM

HEALTH AUTHORITY INFORMATION

Date of Report: Y <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/>	Health Authority:
Person Reporting:	Phone: ()

PATIENT INFORMATION

Last Name:	First Name:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	PHN:
Community of Residence and Postal Code:	Date of Birth: Y <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/>

CLINICAL HISTORY

Onset of Illness: Y <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/>	Chief or Presenting Complaint: _____
ECM/Erythema Chronicum Migrans present? (Red, circular expanding lesion(s) 48hrs after tick bite, 5cms in diametre)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cranial Neuritis (e.g. Bell's Palsy): <input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent brief joint effusion: <input type="checkbox"/> Yes <input type="checkbox"/> No
Lymphocytic Meningitis: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, was this followed by chronic arthritis?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Radiculoneuropathy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment with antibiotics?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Encephalomyelitis: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify: (type/dose/duration) _____
2 nd or 3 rd degree A-V Block: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lyme Disease Vaccine?: <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, date: Y <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/>

TICK EXPOSURE HISTORY

Does patient recall being bitten by a tick? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: Y <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/>
If yes, (as close as possible) closest: Park/Town/City _____ Province/State _____ Country _____	
If no, was patient exposed to brushy or grassy areas where tick bite may have occurred? If yes, date: Y <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/>	
If yes, (as close as possible) closest: Park/Town/City _____ Province/State _____ Country _____	

LABORATORY DATA (For BCCDC Lab Use Only)

Was Lyme Serology Drawn? <input type="checkbox"/> Yes <input type="checkbox"/> No	Lab Result Interpretation (for below): R=Reactive; N=Non-Reactive; E=Equivocal							
	Serum Date			Screening	Confirmatory IgM	Confirmatory IgG		
	Year	Mo.	Day					
Serology 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Serology 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Serology 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If Culture taken, date?:	Y <input type="text"/>	<input type="text"/>	<input type="text"/>	M <input type="text"/>	<input type="text"/>	D <input type="text"/>	<input type="text"/>	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
If PCR taken, date?:	Y <input type="text"/>	<input type="text"/>	<input type="text"/>	M <input type="text"/>	<input type="text"/>	D <input type="text"/>	<input type="text"/>	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative