BC Centre for Disease Control
Provincial Health Services Authority

Tick-borne Infections Case Report Form

655 West 12th Avenue
Vancouver, BC V5Z 4R4
Email ezvbepi@bccdc.ca

Confidential once completed. If requested by BCCDC, email to ezvbepi@bccdc.ca or fax to 604-707-2516.

This form is applicable to all tick-borne infections including anaplasmosis, babesiosis, *B. hermsii* infection (tick-borne relapsing fever), ehrlichiosis, Powassan virus, and Rocky Mountain spotted fever, **excluding Lyme disease**, for which the Lyme disease case report form should be utilized.

PERSON REPORTING

Health authority: ☐ FHA ☐ IHA ☐ ISLH ☐ NHA ☐ VCH Date report received: YYYY-MM-DD

Name: Phone: Email:

Contact attempt 1: YYYY-MM-DD 24hr clock Outcome:

Contact attempt 2: YYYY-MM-DD 24hr clock Outcome:

Contact attempt 3: YYYY-MM-DD 24hr clock Outcome:

Contact attempt 4: YYYY-MM-DD 24hr clock Outcome:

Interviewer: Interviewed: ☐ Client ☐ Proxy, specify:

A. REPORTING CONDITION

☐ Anaplasmosis (*Anaplasma phagocytophilum*)
☐ Babesiosis (*Babesia spp.)*
☐ *B. hermsii* infection (*Borrelia hermsii*)
☐ Ehrlichiosis (*Ehrlichia spp.)*
☐ Powassan virus
☐ Rocky Mountain spotted fever (*Rickettsia rickettsii)*

B. CLIENT INFORMATION

Name: Last First Middle

Preferred name: Date of birth: YYYY-MM-DD

PHN: Sex: ☐ Female ☐ Male ☐ X ☐ Undifferentiated ☐ Unknown

Phone: Type: (cell/home/work/other) Phone: Type: (cell/home/work/other)

Address: Unit # Street # Street name City:

Province: Postal code: Email:

Do you wish to self-identify as an Indigenous person? ☐ Yes ☐ No ☐ Asked, not provided ☐ Not asked

If yes, how do you identify? Select all that apply:

☐ First Nations ☐ Inuit ☐ Métis ☐ Asked, but unknown ☐ Asked, not provided ☐ Not asked

If First Nations, status:

☐ Status Indian ☐ Non-status Indian ☐ Asked, but unknown ☐ Asked, not provided ☐ Not asked

C. CLINICAL INFORMATION

Admitted to hospital: ☐ Yes ☐ No ☐ Unknown Hospital name:

Date of admission: YYYY-MM-DD Date of discharge: YYYY-MM-DD

Admitted to intensive care: ☐ Yes ☐ No ☐ Unknown

Date of admission: YYYY-MM-DD Date of discharge: YYYY-MM-DD

C. CLINICAL INFORMATION

Underlying medical conditions (including pregnancy): ☐ Yes ☐ No ☐ Unknown

If yes, specify:

Outcome: ☐ Death ☐ Recovering ☐ Fully recovered ☐ Recovered with complications

If died, date of death: YYYY-MM-DD

Specify complications:

If died, cause of death: ☐ Died from disease ☐ Disease contributed to death (secondary cause) ☐ Died – other causes ☐ Died – unknown cause

D. SIGNS AND SYMPTOMS

Physician name:

Physician phone number:

☐ Clinician information not available

Symptom onset date: YYYY-MM-DD

Response	Symptom
☐ Yes ☐ No ☐ Unknown	Anemia – if yes, specify: ☐ Mild anemia ☐ Hemolytic anemia
☐ Yes ☐ No ☐ Unknown	Anorexia
☐ Yes ☐ No ☐ Unknown	Chills
☐ Yes ☐ No ☐ Unknown	Disorientation
☐ Yes ☐ No ☐ Unknown	Drowsiness
☐ Yes ☐ No ☐ Unknown	Elevated hepatic transaminase
☐ Yes ☐ No ☐ Unknown	Elevated immature neutrophils
☐ Yes ☐ No ☐ Unknown	Fatigue
☐ Yes ☐ No ☐ Unknown	Fever
☐ Yes ☐ No ☐ Unknown	Headache
☐ Yes ☐ No ☐ Unknown	Leukopenia
☐ Yes ☐ No ☐ Unknown	Loss of coordination
☐ Yes ☐ No ☐ Unknown	Malaise
☐ Yes ☐ No ☐ Unknown	Paralysis
☐ Yes ☐ No ☐ Unknown	Rash
☐ Yes ☐ No ☐ Unknown	Respiratory distress
☐ Yes ☐ No ☐ Unknown	Seizures
☐ Yes ☐ No ☐ Unknown	Sore throat
☐ Yes ☐ No ☐ Unknown	Speech difficulties
☐ Yes ☐ No ☐ Unknown	Sweating
☐ Yes ☐ No ☐ Unknown	Thrombocytopenia
☐ Yes ☐ No ☐ Unknown	Vomiting
☐ Yes ☐ No ☐ Unknown	Other, specify:

E. LABORATORY INFORMATION

Specimen type	Reporting lab	Collection	Test	Result (titres if applicable)	Etiologic agent
		YYYY-MM-DD			
		YYYY-MM-DD			
		YYYY-MM-DD			
		YYYY-MM-DD			

F. RISK FACTORS AND EXPOSURE INFORMATION

In the 6 months prior to symptom onset did you donate or receive blood, plasma, or blood components?*

☐ Yes, donated ☐ Yes, received ☐ No ☐ Unknown If yes, date: YYYY-MM-DD

Hospital/clinic/physician:

City: Province/territory:

Additional details:

***If client was a donor and/or recipient of blood/plasma/platelets or bone marrow,** please notify Canadian Blood Services via the 24-hour call line 604-876-7219 or fax 604-879-6669.

In the 6 months prior to symptom onset did you donate or receive organs or tissues?^

☐ Yes, donated ☐ Yes, received ☐ No ☐ Unknown If yes, date: YYYY-MM-DD

Hospital/clinic/physician:

City: Province/territory:

Additional details:

^If client was a donor and/or recipient of organs or tissues, please notify the local Medical Health Officer.

In the month prior to symptom onset did you experience a tick bite?

☐ Yes ☐ No ☐ Unknown If yes, date of tick bite: YYYY-MM-DD

If yes, please describe where you were when the bite occurred (e.g., name and location of park or walking trail in addition to any identifiable landmarks such as a lake, picnic area, playground):

G. RISK FACTORS AND EXPOSURE INFORMATION

In the month prior to symptom onset did you travel? ☐ Yes ☐ No ☐ Unknown

If yes: ☐ Within BC ☐ Outside BC but within Canada ☐ Outside Canada

Dates	**Details** (e.g., city, country, outdoor activities while travelling)
Departure: YYYY-MM-DD Return: YYYY-MM-DD	
Departure: YYYY-MM-DD Return: YYYY-MM-DD	
Departure: YYYY-MM-DD Return: YYYY-MM-DD	

H. ADDITIONAL DETAILS RELATED TO CASE INVESTIGATION

Provide any additional exposure details including any relevant travel within British Columbia, if applicable. Include date and name or initials with any additional details.