Maine Center for Disease Control and Prevention
Lyme Disease Case Report Form

Patient Information

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ___/___/_____ Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Amer. Indian/Eskimo ☐ Asian/Pacific Islander ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Occupation: _____

Symptoms and Signs of Current Episode: Please Answer Each Question

		Yes	No	Unk
Dermatologic:	Erythema migrans (physician diagnosed EM at least 5cm in diameter)..	☐	☐	☐
Rheumatologic:	Arthritis characterized by brief attacks of joint swelling..	☐	☐	☐
Neurologic:	Bell's palsy or other cranial neuritis.	☐	☐	☐
	Radiculoneuropathy..	☐	☐	☐
	Lymphocytic meningitis..	☐	☐	☐
	Encephalitis/Encephalomyelitis..	☐	☐	☐
	CSF tested for antibodies to *B. burgdorferi*	☐	☐	☐
	Antibody to *B. burgdorferi* higher in CSF than serum	☐	☐	☐
Cardiologic:	2nd or 3rd degree atrioventricular block..	☐	☐	☐

Date of Onset of First Symptoms: ___/___/_____ Date of Diagnosis: ___/___/_____

Patient diagnosed with Lyme disease in the past? ☐ Yes ☐ No ☐ Unk If yes, month/year: ___/_____

Patient tested for other tickborne diseases? ☐ Yes ☐ No ☐ Unk If yes, which one(s): ☐ Anaplasmosis ☐ Babesiosis ☐ Ehrlichiosis ☐ RMSF ☐ Tularemia

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unk If yes, hospital: _____

Pregnant at time of diagnosis? ☐ Yes ☐ No ☐ Unk

Exposure Information

Where was the patient exposed? Town: _____ County: _____ State: _____

History of Tick Bite? ☐ Yes ☐ No ☐ Unk

Laboratory Findings

- Please send a copy of all Lyme disease testing.
- Without laboratory report, form will be incomplete and not counted, except when Erythema migrans is present.

Diagnosis (Please Check One Option)

☐ Yes, this patient has been diagnosed with Lyme disease.

☐ This patient is still undergoing evaluation. Please contact me again in ☐ 15 ☐ 30 ☐ 60 days.

☐ I do not believe this patient has Lyme disease.

☐ Please contact the following health care provider to obtain information about this patient:

Other Provider's Name: _____

Provider/Reporter Information

Provider's Name: _____ Telephone Number: _____

Address: _____ City: _____ State: _____

Date Sent by Maine CDC: ___/___/_____ Date Returned: ___/___/_____

Reviewed 5/2014

Maine CDC Fax: 1-207-287-6865