

Form A: – Tool to assess clinical characteristics of Lyme disease for healthcare providers



Dear Healthcare Provider:

The _____ County Health Department has been notified of a positive laboratory report of Lyme disease for patient _____ (DOB: ____/____/____). In order to comply with state and federal infectious disease reporting requirements, we are requesting the following clinical details about this patient’s Lyme disease (LD) symptoms, if present. Please respond to the following questions and return this completed sheet via fax to (304)____ - _____ within 72 hours of receipt.

A. Date of first symptom onset (month/day/year): ____ / ____ / _____

B. Was an erythema migrans measuring at least 5 cm in diameter documented for this patient?

YES NO

C. Did patient exhibit any of the following symptoms of late-stage Lyme disease?

I. **Rheumatologic/musculoskeletal** (mark one):

- Migratory pain in joints, bone, or muscle Brief arthritis attacks
- Prolonged arthritis Chronic arthritis
- No rheumatologic/musculoskeletal symptoms associated with LD were observed

II. **Neurologic** (mark all that apply):

- Meningitis Bell’s palsy Cranial neuritis
- Radiculoneuritis Encephalopathy Polyneuropathy
- Leukoencephalitis No neurologic symptoms associated with LD were observed

III. **Cardiovascular** (mark one):

- Myopericarditis Pancarditis Atrioventricular block
- No cardiac symptoms associated with LD were observed

D. Was this patient diagnosed with Lyme disease? YES NO

E. Why was the Lyme disease test ordered for this patient? Mark all that apply.

- Patient had clinical evidence of infection Patient requested Lyme testing
- Patient had exposure to tick habitats Other: _____

F. Was an antibiotic prescribed? YES NO

If yes, indicate type of antibiotic and # of days: _____

Comments: _____

Thank you for your cooperation.

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