Patient's Name: _____ First Name: _____ Phone No.: ( ) _____

Address: _____ City: _____

Detach before sending to CDC

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

LYME DISEASE CASE REPORT

Approved OMB No. 0920-0004

State:	County:	Zip:

Age:	Sex:	Patient Ethnicity: (select one)	Patient Race: (select all that apply)
	☐ Male ☐ Female ☐ Unspecified	☐ Hispanic/Latino ☐ Unk ☐ Not Hispanic/Latino	☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Unk

– SYMPTOMS AND SIGNS OF CURRENT EPISODE – *(PLEASE MARK EACH QUESTION)*

DERMATOLOGIC:

Erythema migrans (**physician diagnosed EM at least 5 cm in diameter**) . . . . . ☐ Yes ☐ No ☐ Unk

RHEUMATOLOGIC:

Arthritis characterized by brief attacks of joint swelling . . . . . ☐ Yes ☐ No ☐ Unk

NEUROLOGIC:

Bell's palsy or other cranial neuritis . . . . . ☐ Yes ☐ No ☐ Unk
Radiculoneuropathy . . . . . ☐ Yes ☐ No ☐ Unk
Lymphocytic meningitis . . . . . ☐ Yes ☐ No ☐ Unk
Encephalitis/Encephalomyelitis . . . . . ☐ Yes ☐ No ☐ Unk
CSF tested for antibodies to B. burgdorferi . . . . . ☐ Yes ☐ No ☐ Unk
Antibody to B. burgdorferi higher in CSF than serum . . . . . ☐ Yes ☐ No ☐ Unk

CARDIOLOGIC:

2nd or 3rd degree atrloventricular block . . . . . ☐ Yes ☐ No ☐ Unk

Other clinical: _____

Date of onset of first symptoms:	Date of diagnosis:	Date of report to health agency
Mo. Day Year	Mo. Day Year	Mo. Day Year

– OTHER HISTORY –

Was the patient hospitalized for the current episode . . . . . ☐ Yes ☐ No ☐ Unk

Name of antiblotic(s) used this episode_____ Use in days _____

Was the patient pregnant at the time of illness . . . . . ☐ Yes ☐ No ☐ Unk

Where was the patient most likely exposed: County _____ State: _____

– LABORATORY RESULTS –

Serologic test results:	Positive	Negative	Equivocal	Not done/Unk
EIA/IFA	☐	☐	☐	☐
Western blot	☐	☐	☐	☐
Culture results:	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

Physician's name:	Phone No.	Person completing form:	Phone No.
	( )		( )

Address:	Address:

– FOR INTERNAL USE ONLY –

State ID No.	CDC ID No.	Date reported to CDC
		Mo. Day Year

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0004). Do not send the completed form to this address.

LYME DISEASE NATIONAL SURVEILLANCE CASE DEFINITION

Lyme disease is a systemic, tick-borne disease with protean manifestations, including dermatologic, rheumatologic, neurologic, and cardiac abnormalities. The best clinical marker for the disease is the initial skin lesion. erythema migrans (EM), that occurs in 60% to 80% of patients.

A case of Lyme disease is defined as follows:

1. A person with erythema migrans; or
2. A person with at least one late manifestation and laboratory confirmation of infection.

NOTE: *It should be emphasized that is an epidemiologic case definition intended for surveillance purposes only.*

General clinical epidemiologic definitions:

1. Erythema migrans (EM):

For purposes of surveillance, EM is a skin lesion that typically begins as a red macule or papule and expands over a period of days or weeks to form a large round lesion, often with partial central clearing. A solitary lesion must reach at least 5 cm in size. Secondary lesions may also occur. Annular erythematous lesions occuring within several hours of a tick bite represent hypersensitivity reactions and do not qualify as EM. In most patients, the expanding EM lesion is accompanied by other acute symptoms, particularly fatigue, fever, headache, mild stiff neck, arthralgias, or myalgias. These symptoms are typically intermittent. The diagnosis of EM must be made by a physician. Laboratory confirmation is recommended for persons with no known exposure.

2. Late manifestations:

These include any of the following when an alternate explanation is not found.

a. Musculoskeletal system:

Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints sometimes followed by chronic arthritis in one or a few joints. Manifestations not considered as criteria for diagnosis include chronic progressive arthritis not preceeded by brief attacks and chronic symmetrical polyarthritis. Additionally, arthralgias, myalgias, or fibromyalgia syndromes alone are not accepted as criteria for musculoskeletal involvement.

b. Nervous system:

Lymphocytic meningitis, cranial neuritis, particularly facial palsy (may be bilateral), radiculoneuropathy or rarely, encephalomyelitis alone or combination. Encephalomyelitis must be confirmed by showing antibody production against B. burgdorferi in the cerebrospinal fluid (CSF), demonstrated by a higher titer of antibody in CSF than in serum. Headache, fatigue, paresthesias, or mild stiff neck alone are not accepted as criteria for neurologic involvement.

c. Cardiovascular system:

Acute onset, high grade (2nd or 3rd degree) atrioventricular conduction defects that resolve in days to weeks and are sometimes associated with myocarditis. Palpitations, bradycardia, bundle branch block, or myocarditis alone are not accepted as criteria for cardiovascular involvement.

3. Exposure:

Exposure is defined as having been in wooded, brushy, or grassy areas (potential tick habitats) in an endemic county no more than 30 days prior to the onset of EM. A history of tick bite is not required.

4. Endemic county:

An endemic county is one in which at least 2 definite cases have been previously acquired or a county in which a tick vector has been shown to be infected with B. burgdorferi.

5. Laboratory confirmation:

Laboratory confirmation of infection with B. burgdorferi is established when a laboratory isolates the spirochete from tissue or body fluid, detects diagnostic levels of IgM or IgG antibodies to the spirochete in serum or CSF, or detects a significant change in antibody levels in paired acute and convalescent serum samples. States may determine the criteria for laboratory confirmation and diagnostic levels of antibody. Syphilis and other known causes of biologic false positive serologic test results should be excluded, as appropriate, when laboratory confirmation has been based on serologic testing alone.