Babesiosis Case Report

Call (or fax) MCDH CD Program to report cases

Phone: 815.334.4500 Fax: 815.334.0191 (Fax lab result with this form)

Demographics:

Patient's last name_____ First name_____ DOB_____/_____/_____

Parent/Guardian Name, if applicable_____

Home Phone_____Cell Phone_____Work Phone_____

Street Address _____ City_____ ZIP Code_____

Sex ☐ Male ☐ Female

Race ☐ White ☐ Black ☐ Asian/ Pacific Islander ☐ Native American ☐ Unknown

Ethnic origin ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Physician_____Phone_____

General Illness/Clinical Presentation:

Date of onset: (mo/day/yr)_____/_____/_____

Diagnosis Date: (mo/day/yr)_____/_____/_____

Was the patient seen in an emergency department? ☐ YES ☐ NO

ER Hospital: _____

Was the patient admitted to a hospital? ☐ YES ☐ NO

Hospital:_____

Admission Date : (mo/day/yr) ___/___/_____

Discharge Date: (mo/day/yr) ___/___/_____

Clinical

Fever ☐ Yes ☐ No

If yes, highest temperature: _____°F

Chills ☐ Yes ☐ No

Sweats ☐ Yes ☐ No

Headache ☐ Yes ☐ No

Myalgia ☐ Yes ☐ No

Arthralgia ☐ Yes ☐ No

Malaise ☐ Yes ☐ No

Fatigue ☐ Yes ☐ No

Generalized Weakness ☐ Yes ☐ No

Enlarged Liver ☐ Yes ☐ No

Severe Hemolytic Anemia (hemolysis) ☐ Yes ☐ No

Acute Respiratory Distress Syndrome (ARDS) ☐ Yes ☐ No

Thrombocytopenia, platelet count <100,000/mm3 ☐ Yes ☐ No

Lowest Platelet Count: _____

Anemia (hemoglobin < 12.0g/dl) ☐ Yes ☐ No

Elevated Liver Enzymes (AST >35U/L; ALT>35U/L) ☐Yes ☐No

Protein in urine ☐ Yes ☐ No

Blood in urine ☐ Yes ☐ No

Renal Failure ☐ Yes ☐ No

Elevated BUN ☐ Yes ☐ No

Elevated Creatinine ☐ Yes ☐ No

Has patient's spleen been removed ☐ Yes ☐ No

Impaired immune function ☐ Yes ☐ No

Ever been on immunosuppressive therapy ☐ Yes ☐ No

Disseminated Intravascular Coagulation (DIC) ☐ Yes ☐ No

Hemodynamic instability ☐ Yes ☐ No

If yes, Lowest SBP: _____ Lowest DBP: _____

Myocardial Infarction ☐ Yes ☐ No

Altered Mental Status ☐ Yes ☐ No

Patient's last name_____ First name_____ DOB:_____/_____/_____

If patient did not have any of the previous listed clinical symptoms, please indicate why patient was tested and what symptoms were present_____

_____

_____

Laboratory Reports (Complete information below or fax copy of complete lab results with this report):

Laboratory Used_____Date Collected_____/_____/_____

Did the physician diagnose the patient with Babesiosis? □ Yes □ No

Fax the Babesiosis lab result back with this case report form for review.

Risk Factors:

Did the patient have any unusual or significant travel?
If yes, where _____
Dates of travel: Departure _____/ _____/ _____ Return _____/ _____/ _____

Tick Habitat Exposure (e.g. tall grass, pasture, woods, brush) □ Yes □ No

When did patient enter tick habitat? (mo/day/yr)_____/_____/_____

When did patient leave tick habitat? (mo/day/yr)_____/_____/_____

Where was the patient in a tick

habitat?_____

Known Tick Bite □ Yes □ No Date of bite(mo/day/yr)_____/_____/_____

Where was the tick bite obtained?_____

Please fax positive lab result with this form. Thank you.