EHRLICHIOSIS/ANAPLASMOSIS INVESTIGATION FORM

PERSON PROVIDING INFORMATION

Name of Person Being Interviewed: _____ Relationship to Patient: _____ Preferred Language: _____

If patient is less than 18 years old, provide parent/proxy's name: _____

Has the patient or patient's proxy been notified by the reporter of this diagnosis or lab result? ☐No ☐Unknown ☐Yes

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: ___/___/_____ Age:_____☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death:_____/_____/_____

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____Work Phone: (_____) _____-_____Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __/____/ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report:_____/ __/ _____Reporting Source:_____

CLINICAL

Physician's Name:_____Phone Number: (_____) - __ __ - __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: ___/___/_____ Discharge Date: ___/___/_____ Duration of Stay_____day(s)

Diagnosis Date: ___/___/_____ Illness Onset Date: ___/___/_____ Illness End Date: ___/___/_____

Age at Onset:_____☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: ___/___/_____

Does the patient have pelvic inflammatory disease? ☐No ☐Unknown ☐Yes

LABORATORY INFORMATION

Did the patient have:

Reported fever?	☐No ☐Unknown ☐Yes
Headache?	☐No ☐Unknown ☐Yes
Myalgia?	☐No ☐Unknown ☐Yes
Anemia (low RBCs)?	☐No ☐Unknown ☐Yes
Leukopenia (low WBCs)?	☐No ☐Unknown ☐Yes
Thrombocytopenia (low platelets)?	☐No ☐Unknown ☐Yes
Hepatic transaminase elevation?	☐No ☐Unknown ☐Yes

ADMINISTRATIVE

General Comments:_____

JEFFERSON COUNTY SUPERVISOR REVIEW

Date Due: __/ __/ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review:_____/_____/_____ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

SIGNS AND SYMPTOMS

Clinical Evidence:

Any reported fever: ☐No ☐Unknown ☐Yes Headache: ☐No ☐Unknown ☐Yes Myalgia: ☐No ☐ Unknown ☐Yes

Anemia: ☐No ☐Unknown ☐Yes Leukopenia: ☐No ☐Unknown ☐Yes Thrombocytopenia: ☐No ☐ Unknown ☐Yes

Any hepatic transaminase elevation: ☐No ☐Unknown ☐Yes