

BABESIOSIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

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

Suffix: _____ DOB: ___/___/_____

Reported Age: _____ • days • hours • months • unknown • weeks • years Current Sex: • Female • Male • Unknown

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

Marital Status: _____

Street Address 1: _____ Street Address 2: _____

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

Country: _____

Home Phone: (____) _____-_____ Cell Phone: : (____) _____-_____ Work Phone: : (____) _____-_____ Ext. _____

Ethnicity: • Hispanic or Latino • Not Hispanic or Latino • Unknown

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

INVESTIGATION SUMMARY

Investigation Start Date: ___/___/_____ Investigation Status: • Open • Closed

Investigator: _____ Date Assigned to Investigation: ___/___/_____

REPORTING SOURCE

Date of Report: ___/___/_____ Reporting Source: _____

Earliest Date Reported to County: ___/___/_____ State: ___/___/_____

Reporter: _____

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)

Condition

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

Illness Duration: _____ • days • hours • minutes • months • unknown • weeks • years

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

Is the patient pregnant? • No • Unknown • Yes

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

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

EPIDEMIOLOGIC

Is the patient associated with a daycare facility? · No · Unknown · Yes

Is the patient a food handler? · No · Unknown · Yes

Is this case part of an outbreak? · No · Unknown · Yes

Where was the disease acquired? Indigenous, within jurisdiction Out of Country Out of jurisdiction, from another jurisdiction
 Out of State Unknown

If the answer is out of country, jurisdiction, or state, where was the disease imported from?

Country: _____ State or Territory: _____ City: _____ County: _____

Transmission Mode: Airborne Bloodborne Dermal Foodborne Indeterminate Mechanical
 Nosocomial Sexually Transmitted Transplacental transmission Vectorborne Waterborne Zoonotic
 Unknown

Detection method: Provider reported Patient self-referral Prenatal testing Prison entry screening Routine physical
 Other

Confirmation method: Active Surveillance Case/Outbreak Investigation Clinical diagnosis (non-laboratory confirmed)
 Epidemiologically linked Laboratory confirmed Laboratory report Local/State specified
 Medical record review No information given Occupational disease surveillance Provider certified
 Other _____

Confirmation date: ___/___/_____

Case Status: Confirmed Not a Case Probable Suspect Unknown

MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General Comments:

CUSTOM FIELDS

(For State-level Use Only) ARWFTI: _____

(For State-level Use Only) CSV: _____

County of Usual Residence: _____

Refer to [Guidelines for Determining Residency for Disease Notification Purposes](#)

JEFFERSON COUNTY ONLY

Date Due: ___/___/_____

Investigation ready for supervisor review: · Reviewed (Complete) · Reviewed (Incomplete) · Reviewed (Not a case) · Yes

Date investigation ready for supervisor review: ___/___/_____

Review comments (completed by supervisor):

CONDITION SPECIFIC CUSTOM FIELDS

SIGNS AND SYMPTOMS

Objective

Fever ($\geq 100.4^{\circ}\text{F}$): No Unknown Yes Anemia: No Unknown Yes Thrombocytopenia: No Unknown Yes

Subjective:

Arthralgia (joint pain): No Unknown Yes Headache: No Unknown Yes Sweats: No Unknown Yes
Chills: No Unknown Yes Myalgia (muscle pain): No Unknown Yes

EPIDEMIOLOGIC EVIDENCE FOR POTENTIAL TRANSFUSION TRANSMISSION

Did the patient donate blood during the **21 days** before illness onset? No Unknown Yes Donation Date: ___/___/_____
Did the patient receive a blood or plasma transfusion during the **1 year** prior to specimen collection? No Unknown Yes
Transfusion Date: ___/___/_____
Was the transfusion epi-linked to a confirmed or probable case? No Unknown Yes
If yes, enter NBS Investigation IDs of cases:

CONTROL MEASURES

Date ADPH Investigator verbally provided patient, or patient representative, with control measures: ___/___/_____
If control measures were not verbally provided (or not provided within the recommended time frame), explain:

Educations case/contacts: No Not Applicable Yes
Identification of additional cases/exposed individuals and contact tracing: No Not Applicable Yes