Putnam County Department of Health

Anaplasmosis/Ehrlichia chaffeensis/Babesiosis

Reporting Form

Patient Information	
Name:	Sex: □ Male □ Female
Address:	Pregnant: □Yes □No □ N/A
City: State: NY Zip:	Ethnicity: Hispanic? □Yes □No
Telephone:	Race:
Date of Birth:	Occupation:

Physician:	Phone #

Was patient hospitalized: □Yes □No *If yes, then*	
Hospital Name:	Medical Record #:
City: State:	Date of Admission:

Clinical Information

Date of First Symptom: _____/_____/______ **Date of Exam:** _____/____/_____

*** Note: Critical Question, please answer:**

*** Fever** ☐Yes ☐ No *** If yes, highest temperature** _____________

Malaise	□Yes □No	**Arthraglia**	□Yes □No	**Stiff Neck**	□Yes □No
Myalgia	□Yes □No	**Rash**	□Yes □No	**Chills**	□Yes □No
Headache	□Yes □No	**Rigors**	□Yes □No	**Nausea**	□Yes □No
Anemia	□Yes □No	**Leukopenia**	□Yes □No	**Thrombocytopenia**	□Yes □No
Hepatic Transaminase Elevation	□Yes □No	**Other:**			

Underlying Medical Conditions

Y N
☐ ☐ ImmunoSuppression

Y N
☐ ☐ Asplenia

Other Medical Conditions _________________________

Recent Illnesses/Surgeries_______________________

Travel

Outside of the Country: □Yes □No □Unk
If yes, where?: ________________________________
Date of Departure & Return: ______________________

Outside of the State: □Yes □No □Unk
If yes, where?: ________________________________
Date of Departure & Return: ______________________

Outside of the County: □Yes □No □Unk
If yes, where?: ________________________________
Date of Departure & Return: ______________________

Blood Transfusion & Tissue/Organ Transplant

In the 6 months before illness, did the patient receive a blood transfusion or platelets? ☐ Yes ☐ No
Date: ____/____/____ Hospital: ________________________________

In the 6 months before illness, did the patient donate blood/blood components? ☐ Yes ☐ No
Date: ____/____/____ Donation site: ____________________________

Did the patient ever receive a tissue or organ transplant? ☐ Yes ☐ No
Date: ____/____/____ Hospital: ________________________________

If transfusion/transplant associated infections, was an infected donor identified? ☐ Yes ☐ No

In the 6 months before illness, did patient donate tissue/organ? ☐ Yes ☐ No
Date: ____/____/____ Hospital: ________________________________

Laboratory Results:

Spec Coll Date	WBC x 1000	RBC	HGB	% HCT	Platelets x 1000	AST (SGOT)	ALT (SGPT)
__/___/___							
__/___/___							

Did patient receive treatment? ☐Yes ☐No

Date Treatment Initiated: _____/_____/______

Duration Prescribed: ☐ 1 Day ☐7 Days ☐ 10 Days ☐ 14 Days ☐21 Days ☐28 Days ☐Other

Medication:

☐ Atovaquone ☐Azithromycin ☐Clindamycin ☐Quinine ☐ Doxycycline

☐ Other _______________

Form completed by: ______________________________________ Date: _________________

Please return completed form by fax to: 845-808-1336