LYME LIST: Patients with EM (Bull's Eye Rash)
FAX THIS LIST TO PCDOH: (845) 808-1336

Patient Name Last Name, First Name	**DOB** mm/dd/yy	**Address** Street Name	**Zip**	**Sex** M/F	**Race** WH/AA/OTH	**Ethnicity** H/N-H	**Date of Visit** mm/dd/yy	**Treated** With what?	**# of Days Treated**	**MD or provider name**

Created 4/2014 RG